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 October 1, 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 October 1, 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 Special Needs Plans, the provider should refer to the Sentara Health Plans Commercial and Dual 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 made available from time to time. 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").

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

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.

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 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. Participating providers include, but are not limited to, licensed professional counselors, marriage and family therapists, board-certified behavioral analysts, nurse midwives, nurse practitioners, certified registered nurse anesthetists (CRNAs), physician assistants, participating hospitals, and other licensed health or mental healthcare professionals, as designated by Sentara Health Plans, in its sole discretion.

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

Sentara Health Plans Key Contact Information

Topic	Website Address	Medicaid Program Phone	Information
24-hour Nurse Advice Line	24/7 Nurse Advice Line	**Phone:** 1-833-933-0487	
Authorizations	Authorizations	**Medical/Pharmacy Phone:** 1-888-946-1167 **Behavioral Health Phone:** 1-888-946-1168 **Behavioral Health Inpatient (IP)/ARTS/Crisis Fax:** 1-844-348-3719 **Behavioral Health Outpatient (OP) Fax:** 1-844-895-3231 **Medicaid OP/Durable Medical Equipment (DME):** Fax: 1-844-348-3720 **Medicaid Urgent Fax:** 1-844-857-6409 **LTSS UM Authorization Fax:** 1-844-828-0600 **LTSS UM New Waivers** Fax: 1-844-857-6408 **LTSS All Other Waiver Requests Fax:** 1-844-828-0600 **Medicaid IP Fax:** 1-844-220-9565 **Medicaid**	The preferred method to obtain preauthorization is through the Sentara Health Plans secure provider portal.

		POSTACUTE Fax: 1-844-220-9572 **Govt Newborn Enrollment Fax:** 1-844-883-6064	
Behavioral Health Member Crisis Line	Behavioral Health Provider Resources	**Phone:** 1-833-686-1595 (Toll Free)	
Care Management		**Phone:** 1-866-546-7924	Monday through Friday from 8 a.m. to 5 p.m., EST. After hours, please contact Member Services. Fax: 1-844-552-7508 Medical Reports, 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		Mailing address 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		**Phone:** 1-877-865-9075	For initial credentialing questions, email SHPInitialCred@sentara.com For re-credentialing questions, email SHPrecred@sentara.com
Critical Incidents	Critical Incident Reporting Information	**Phone:** 757-252-8400	CIReporting@sentara.com

	(under How To…) Provider Critical Incident Form (under Forms)	option 1 1-844-620-1015 option 1 **Fax:** 804-200-1962 **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 at** 1-800-884-9730 or 1-804-965-9732	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 Payment Network Customer Service:** 11-855-496-1571	zelis.com/providers/provider-enrollment/
Interactive Voice Response System (IVR)		**Main Phone Line 24-hour IVR:** 1-800-229-8822	To verify eligibility, providers should utilize the Sentara Health Plans IVR System.
Medical Authorizations, Medical Benefit, Drugs for Medicaid Products		**Provider Services Main Phone:** 1-800-229-8822 Fax numbers for specific services are located on the authorization fax forms.	Medical benefit questions and pharmacy needs
Medical Records		**Phone:** 1-844-620-1015 option 2	Email for medical record requests: SHP_quality@sentara.com
Member Services	Sentara Health Plans Members	**Phone:** 1-800-881-2166 (Hearing Impaired/VA Relay: 711)	Members can contact Sentara Health Plans for various concerns and questions.

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			contactmyrep@sentara.com
Participation in Medicaid Fee-for-Service (DMAS)	DMAS MES Portal	Virginia Medicaid Provider Enrollment Helpline **Phone:** 1-888-829-5373	To review frequently asked questions on the Provider Services Solution (PRSS) portal, please visit the MES website.
Pharmacy Services	Pharmacy Sentara Case Management Pharmacy	**Pharmacy Provider Services Phone:** 1-844-672-2307 **Specialty Pharmacy (Sentara Case Management Pharmacy) Phone:** 1-877-349-5242 **Web:** sentaracasemanagement.com **Pharmacy Authorizations Phone:** 1-800-881-2166	
Program Integrity (Fraud, Waste, and Abuse)	Fraud, Waste, and Abuse (FWA) Information and Training	**FWA Hotline Phone** 757-687-6326 or 1-866-826-5277	compliancealert@sentara.com
Provider Services	Provider Services	**Phone:** 1-800-229-8822	Contact Sentara Health Plans Medicaid program provider customer service for most concerns
Sentara Health Plans Website	Sentara Health Plans		A 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.

Interpreter Services

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

Providers are to contact Sentara Health Plans provider customer service for interpreter services: 1-800-229-8822. 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 payor. If a Medicaid program member has no other means of transportation, transportation will be provided to and from medical appointments.

Sentara Health Plans has a contracted vendor to administer the transportation program. The member is expected to call 1-877-892-3986 at least five days in advance of a scheduled covered service to have transportation arranged. For more transportation information, 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 program is to improve the lives, satisfaction, and health outcomes of participants by providing a seamless, one-stop system of services/supports and assisting with navigating the complex service environment. By integrating medical and social models of care, supporting seamless transitions between service settings, and facilitating communication between providers, Sentara Health Plans will ensure members receive person-centered care driven by individual choice and rights.

Medicaid Program Members

The Cardinal Care population is composed of the following population groups:

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

DMAS Contracted Enrollment Broker

The DMAS and Managed Care Helpline contract with CoverVA to provide enrollment services for Medicaid program enrollees. Eligible recipients interested in enrolling may call Cover Virginia at 1-855-242-8282 or visit the CoverVA website at coverva.dmas.virginia.gov/ to request an application. Applications are also available at local DSS offices.

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 at login.vamedicaid.dmas.virginia.gov/ or by contacting the toll-free MediCall Automated System at 1-800-772-9996 or 1-800-884-9730.

- To verify eligibility for Sentara Health Plans, providers should utilize the Sentara Health Plans interactive voice response (IVR) system, Availity, 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 our 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 member or hospital must report the birth. The birth member must report the birth of the child by calling the Cover Virginia Call Center at 1-855-242-8282 or by contacting the member's local Department of Social Services (DSS). The hospital should report the birth by using the DMAS automated method for enrolling deemed newborns. Hospitals should submit newborn enrollment through the Newborn/Newborn E213 link on the DMAS Medicaid Enterprise System (MES) portal.

Once Medicaid-enrolled, the newborn is enrolled in the birth member'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 from at: newborn-providers@dmas.virginia.gov.

Member Handbook and Guide

Sentara Health Plans members may access the Member Handbook, which explains the members' healthcare rights and responsibilities.

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

Access sample member identification cards for Sentara Health Plans here.

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

Sentara Health Plans Provider Services Team

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

- Member eligibility
- Benefits information
- Claims 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. The requirement to enroll is included in the Sentara Health Plans Provider Agreement under the Medicaid obligation mandated provision.

Network providers that are currently enrolled as FFS in Medicaid do not have to reenroll in PRSS. However, all new MCO-only providers must first enroll with PRSS 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 network, providers must have a contract and be credentialed (as applicable) with Sentara Health Plans. To request a contract with Sentara Health Plans, providers must complete and submit a Request for Participation form to the Sentara Health Plans network management contracting team.

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

All providers should review the Provider Contracting and Credentialing Guide found under “How To…”. Access the complete credentialing program description for Sentara Health Plans here.

Credentialing Overview

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

The goals of the Sentara Health Plans credentialing/recredentialing policy are to 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 shall, at a minimum, recredential all providers every 36months 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 shall be denied or terminated from network participation based on their age, sex, race, ethnicity, religion, national origin, or disability.

Scope

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 network practitioners that are part of Sentara Health Plans primary network and Sentara Health Plans has members who reside in the rental area.
- 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 information about the network is included in member materials or on a member ID Card that directs members to use the network or there are incentives for members to see the PPO network practitioners.
- Locum Tenens practitioners who either 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 as a result 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 as a result 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 as a result 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 ensures that LTSS providers are credentialed and re-credentialed 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 determines if the provider meets minimum participation and credentialing criteria. Applicants with a felony conviction, Office of Inspector General (OIG) sanction(s) or Excluded Parties List System (EPLS) sanctions will not be accepted. LTSS Providers shall identify and report all Legally Responsible Information (LRI) 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 - Sign In
CAQH Provider Help Desk: **1-888-599-1771** or email providerhelp@proview.caqh.org.

Supporting Documents

In addition to the completed CAQH application, all practitioners must submit the following supporting documents to Sentara Health Plans or CAQH:
- Current state medical licenses.
- 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 $2,650,000 per occurrence) and twice that amount (currently $5,300,000) annual aggregate. These limits change year to year, and it is advised that the provider review the code annually, upon renewal of their policy, to ensure 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. Non-prescribing Sentara Health Plans behavioral health Virginia, individual non-physician providers must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.

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

Where applicable, 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 CDS/CSR Certificate, but who should have one based on their practice. Such providers 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.
- Practitioners required to have hospital privileges who do not have such privileges must submit appropriate admitting coverage.
- ECFMG certificate if foreign medical school graduate with ECFMG number noted in CAQH.
- Cross coverage forms from covering provider if not within the provider's practice.
- Explanations for malpractice cases.
- Explanations for license sanction or license limitations.

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 notifies a new Provider applicant within ten (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. The Plan uses the Council for Affordable Quality Health Care's (CAQH) Universal Provider Data Source Application found at https://proview.caqh.org as part of our credentialing and recredentialing processes. 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; Plan 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.

- Board certification status

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. Sentara Health Plans may, at its sole discretion, waive the specialty board certification requirement for applicants that meet a certain criterion, not limited to practicing with a specialty required to fill a geo-access gap in an underserved geographic area.

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

Note: Provider must explain any gap(s) 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

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. Provider agrees to furnish information and documentation necessary for Sentara Health Plans to perform credentialing and recredentialing in accordance with such requirements.

A provider credentialing or recredentialing file is deemed complete and ready for medical director or credentialing committee review when a complete application has been received, all supporting documents and/or responses have been received 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 such 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 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 and determined 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, solely on the basis of 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 the 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.

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 below).

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 shall 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 the applicant with information on the status of their credentialing or recredentialing application. Sentara Health Plans will provide status to the applicant within ten business days of receiving their request. Providers will be advised of the date their application was received, the status of the processing of their application including any missing or outstanding information still needed for their file and the expected timeframe for medical director or credentialing committee review for participation determination (no peer-review information or details will be disclosed to the provider). Providers are informed of this right through the credentialing program description which is posted publicly on Sentara Health Plans website. Providers are instructed on the Sentara Health Plans website to contact the credentialing department at SHPCredDept@Sentara.com to request the status of their credentialing application.

An applicant may review any documentation submitted by the applicant in support of their application, together with any information received from outside sources such as malpractice carriers, state licensing agencies or certification boards. Providers may not review any peer

review information obtained by Sentara Health Plans. Providers are informed of this right through the credentialing program description which is posted publicly on Sentara Health Plans website. Providers may choose to request to review such information, at any time, by sending a written request, to the credentialing department online at SHPCredDept@Sentara.com or through the United States Postal Service at:

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

In the event the credentialing or recredentialing verification process reveals information submitted by the 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 Plans' 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 30-calendar 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 and 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.
- When organizational providers are not accredited, Sentara Health Plans shall conduct a quality assessment of the organization.
- Sentara Health Plans may substitute a copy of a review conducted by the Centers for Medicare and Medicaid (CMS) or applicable State review board quality review in lieu of conducting its own quality assessment if the CMS or state assessment is no more than 3-years old. If the CMS or state assessment is older than 3-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.

- Proof of general and professional liability insurance is required in the amount of at least $1 million per occurrence and $3 million per aggregate.
- Validation of active NPI.
- Validation of licensure if applicable.
- Validation of Medicare or Medicaid sanction 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, 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 rendering during the credentialing process, new provider applicants must provide written or electronic notice to covered 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 patient shall only be responsible for any coinsurance, copayments, or deductibles permitted under the insurance contract with the carrier or participating provider agreement with the physician, mental health professional, or other provider. If the new provider applicant is not credentialed by the carrier, the new provider applicant or any entity that employs or engages such physician, mental health professional, or other provider shall not collect any amount from the patient for health care services or mental health services provided from the date the completed credentialing application was submitted to Sentara Health Plans until the applicant received notification from Sentara Health Plans that credentialing was denied.

Disciplinary Action

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

Grounds for corrective action include:

- Quality of care below the applicable standards
- A pattern of over/underutilization of services that is significantly higher/lower than other practitioners

- Failure to comply with utilization management and quality improvement programs
- Violation of the terms of the provider agreement
- Disruptive behavior, including but not limited to 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, logic, 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 ten (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 submitting a new practitioner with 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 are excluded from this limit
- Claims processing and payment are not impacted

If a practitioner has more than 10 locations per group NPI/tax ID combination, prioritize those locations where members should be actively directed for care.

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 (contract) cannot be submitted on the Provider Update Form; these requests should be submitted directly to your Sentara Health Plans contract manager. Please contact the network contracting team at 1-877-865-9075 for these requests.

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) 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)
- Accommodations 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. At least 1 full-time equivalent PCP, regardless of specialty type, for every 1,500 Medicaid program members
2. At least 1 full-time equivalent pediatrician for every 1,500 Medicaid program members under the age of 18

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. Provider sends a certified letter to Sentara Health Plans notifying Sentara Health Plans and stating the reason for asking the member to be repaneled to another provider.
2. 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. 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 dmas.virginia.gov.

After-hours Nurse Advice Line

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

Call the 24/7 Nurse Advise Line: 1-833-933-0487

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

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

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

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

Member Services

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

Continuity of Care for New Members

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

Billing a Medicaid Program Member

A provider may bill a member only when the provider has provided advance written notice to the member before rendering services, indicating that Sentara Health Plans Medicaid program will not pay for the service, and the member has consented. The notice must also state that should the individual decide to accept services that have been denied payment by the Sentara Health Plans Medicaid program, the provider is accepting the member as a private pay patient, not as a Medicaid 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 Opinion

Sentara Health Plans will provide coverage for a second opinion when requested by the member for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. Sentara Health Plans will provide a second opinion from a qualified healthcare professional within the network or arrange for the member to obtain one outside the network at no cost to the member. Sentara Health Plans may require an authorization to receive specialty care from an appropriate provider; however, Sentara Health Plans will not deny a second opinion request 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 such as wide entry, wheelchair access, accessible exam rooms, tables, lifts, scales, bathroom stalls, grab bars, or other accessibility equipment. Members who require special services (e.g., substance use, childbirth classes, smoking cessation) may have these services arranged by Sentara Health Plans to ensure access to such services.

Sentara 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 member's need for interpreter or translation services and provide the appropriate aides and services to meet the member's needs
- Be mindful of the cultures that may have specific beliefs surrounding health and wellness
- Ensure that the member understands diagnosis, procedures, and follow-up requirements
- Offer health education materials in languages that are common to your patient population 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 and/or affiliated 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). Features of the D-SNP include:

- A team of doctors, specialists, and care managers working together for the D-SNP member
- A Model of Care (MOC) that calls for individual care plans for members
- The same member rights available to Medicare and Medicaid recipients

Sentara Health Plans

Beginning January 1, 2025, full benefit dual eligible Medicaid enrollees that have elected to enroll in a type of D-SNP will be assigned to the same health plan for their Medicaid managed care and their D-SNP. This is known as aligned enrollment and is required for all dual-eligible members.

Full benefit dual eligibles who are excluded from Medicaid managed care (such as those who reside in an excluded facility), are enrolled in Medicare Fee-For-Service or a non-D-SNP Medicare Advantage plan, and partial benefit duals will not be impacted.

DMAS will move any eligible dually enrolled member with unaligned enrollment (enrolled with one health plan for their D-SNP and a different health plan for their Medicaid managed care) to the Medicaid managed care plan that matches their D-SNP choice.

Please reference the Sentara Health Plans Dual Eligible Special Needs Plan (D-SNP) Provider Manual found here for more details.

Sentara Health Plans

Section IV: Medical Management

Utilization Management

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

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

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

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

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

Service Authorization

Some services require service authorization from Sentara Health Plans. The service authorization process allows the plan to:

- Verify the member's eligibility.
- Determine whether the service is a covered benefit.
- Make sure that the chosen provider is in the Sentara Health Plans network.
- Evaluate the medical necessity criteria for the service.
- Enter the member into Sentara Health Plans' case or disease management program if appropriate.

To pre-authorize medical or long-term support services, submit a request via the Availity Essentials secure provider portal or contact Sentara Health Plans' UM department at the number listed for the service area. Failure to obtain a service authorization will result in denial of payment and the provider may be held responsible for the services. Please see the Mental Health Services section of this provider manual for clarification of authorization requirements.

Procedure Codes Requiring Service Authorization

For a complete listing of services, please refer to the online Prior Authorization List for coverage and authorization requirements. Providers can contact the UM department for any questions

pertaining to service authorization. For any service that requires authorization, requests must be processed prior to services being rendered, except in case of emergency.

Out-of-Network Providers

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

Out-of-network providers are prohibited from causing the cost to the member to be greater than it would be if the services were furnished within the network. If an out-of-network provider delivers services to a member, Sentara Health Plans will coordinate with the provider for payment and will reimburse the out-of-network practitioner/provider per the Single Case Agreement.

Out-of-Plan Authorizations

Members may utilize out-of-network (OON) providers if an in-network provider is unavailable, does not meet accessibility standards, or does not meet the individual member's needs. Sentara Health Plans will adequately and timely cover, pay for, and coordinate the care if an in-network provider is unavailable to provide them with care in all of the following circumstances:

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

- When the only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the member seeks.

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

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

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

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

Authorization Decision Time Frames

Standard Authorization Decisions

For standard authorization decisions, Sentara Health Plans must provide the decision notice as expeditiously as the Member's health condition requires, not to exceed seven calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if

- the member or the provider requests extension; or
- Sentara Health Plans justifies to DMAS upon request that the need for additional information is in the members' interest.

Expedited Authorization Decisions

For cases in which a provider indicates, or Sentara Health Plan determines, that following the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, Sentara Health Plans will make an expedited

authorization decision. Sentara Health Plans will provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request for service.

Sentara Health Plans may extend the 72-hour turnaround time frame by up to 14 calendar days if the member requests an extension or Sentara Health Plans justifies (to DMAS upon request) a need for additional information and how the extension is in the member's interest.

Service Authorization Decision Timeframes for the Medicaid Program

Sentara Health Plans meets the requirements of 42 CFR § 438.210. All other NCQA requirements or standards must be adhered to. Sentara Health Plans ensures that its service authorization policies and procedures meet NCQA standards and any applicable federal or state requirements related to service authorization. Sentara Health Plans is responsible for determining the classification (i.e., urgent/expedited versus non-urgent/standard) and type (i.e., concurrent versus preservice). This, however, does not preclude a provider from indicating the need for an expedited review.

There will be no extensions to the timeframes below due to weekends or holidays. Sentara Health Plans complies with the following minimum service authorization timeliness standards as described in 42 CFR § 438.210(d)(1) and (2) 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	Seven calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days
Behavioral Health including Mental Health and ARTS Services			
Urgent/Expedited	Concurrent	72 hours	14 calendar days
	Preservice	72 hours	14 calendar days
Non-urgent/Standard	Preservice	Seven calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days

Utilization Management (UM) Staff Availability

UM personnel are available to assist you in expediting care for your Sentara Health Plans patients. UM offices are open from 8 a.m. to 5 p.m. daily. If you call after hours or on a weekend, a confidential voice response system will receive your call. Please leave detailed information and a Sentara Health Plans representative will respond to your call on the next business day.

Hospital Admissions: Elective Admissions

Inpatient and elective hospital admissions, and outpatient ambulatory surgical procedures must be pre-authorized using Medical Policies and/or Milliman Care Guidelines. The admitting physician or his/her designee will notify Sentara Health Plans' UM Department of the planned admission where eligibility will be verified, and baseline information will be obtained, including but not limited to:

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

The UM department will review the request based upon clinical information provided.

1. If authorized, an authorization number will be given to the physician. All hospital stay extensions beyond the originally authorized length of stay will require additional review.
2. If the reported information does not meet Sentara Health Plans established clinical criteria, the medical director will review the request for further consideration.
3. Short stays (less than two midnights) may be identified as observation level of care.

Admission / Concurrent Review

All inpatient hospital stays require authorization. At the time of the review for emergency admission, Sentara Health Plans will determine if the admission was medically necessary. Pending the availability of clinical data, determinations will be made within 72 hours (three calendar days) of Sentara Health Plans' notification with subsequent notification to providers within 72 hours (three calendar days) of making the decision.

Concurrent or continued stay reviews are performed on all non-DRG hospitalized patients and DRG admissions. Medical records will be reviewed to determine if an admission meets the criteria for a continued stay. Continued stay decisions will be communicated by fax or telephone to the requesting facility. Sentara Health Plans will send an approval or denial letter, as applicable. For adverse determinations, the letter will include instructions on submitting an appeal. The facility, attending physician and members are notified in writing of the decision by the expiration date of the authorization.

Medical Necessity Criteria

Sentara Health Plans uses DMAS criteria and MCG 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 an individual determination to members, practitioners, or facilities.

If criteria applicable to a specific determination are not available online or if additional detail is 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 CMS and DMAS guidelines.

Coverage decisions are based upon medical necessity and are in accordance with 42 CFR § 438.210. Sentara Health Plans:

- will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member
- may place appropriate limits on a service based on medical necessity criteria for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose
- will ensure that coverage decisions for individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that fully supports the member's ongoing need for such services and supports and considers the member’s functional limitations by providing services and supports to promote independence and enhance the member’s ability to live in the community
- will ensure that coverage decisions for family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used, consistent with 42 CFR §441.20

Medically appropriate services are determined in a manner that:

- It is no more restrictive than the Medicaid fee-for-service Medicaid program criteria, including, but not limited to, quantitative and non-quantitative treatment limits, as indicated in any laws, regulations and interpretations.
- In accordance with § 438.236, Sentara Health Plans’ medical necessity guidelines are evidence-based and at a minimum:
    - Based on valid and reliable clinical evidence or a consensus of providers in the particular field.
    - Adopted in consultation with contracting health care professionals in the service area.
    - Developed in accordance with standards adopted by national accreditation organizations.
    - Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice.
    - Applied in a manner that considers the individual health care needs of the member.

Sentara Health Plans will ensure that services are authorized in a manner that supports:

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

Concurrent Review

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

Secondary Payer - Service Authorizations

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

- The primary payer does not cover the service and Sentara Health Plans does cover it; or,
- The member has exhausted their benefits under the primary payer, and the service is a benefit under Sentara Health Plans.

In either of these circumstances, Sentara Health Plans becomes the primary payer and service authorization is required, if it is required for the specific service type.

Medicaid plans require service authorization for transplants even as the secondary payer. Please also see Transplants for additional information.

Women's Health Services

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

- Mammograms
- Pap smears
- Cervical cancer screening
- Genetic testing (BRAC)
- Annual physicals and lab tests
- Prenatal and postpartum services for all pregnant members
- Routine and medically necessary obstetric and gynecologic services
- Reconstructive breast surgery
- Certified nurse-midwife services
- Certified and VDH-registered doulas
- Family planning, including sterilizations and hysterectomies
- Mental health and substance misuse care
- Screening and treatment for sexually transmitted diseases
- Counseling services
- Smoking cessation and weight management
- Immunizations
- Lactation services and breast-feeding pump/supplies
- Nutritional assessments

- Homemaker services
- Blood glucose monitors pre and postpartum

Sentara Health Plans does not require referrals or authorizations for preventive services, obstetrical services, or basic prenatal care.

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

Gynecological Care

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

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

Services Upon Identification of Pregnant or Postpartum Member

Providers must promptly notify Sentara Health Plans of any member who is identified as being pregnant or postpartum. When DMAS or Sentara Health Plans identify a pregnant or postpartum individual (either from provider notification or otherwise), Sentara Health Plans will perform the following:

a. Inform the mother/parent/guardian that in order for the newborn to be covered, the mother/parent/guardian must report the birth of the child by either calling the Cover Virginia Call Center at (855) 242-8282 or by contacting the member's local Department of Social Services.
b. Cover pregnancy-related and postpartum services, as appropriate based on aid category or eligibility, as per 12 VAC 30-50-290.
c. Cover services to treat any other medical condition that may complicate pregnancy, as per 12 VAC 30-50-290.
d. Cover prenatal and infant programs as defined in the Cardinal Care Contract.
e. Refer the pregnant or postpartum member to the local WIC program office.
f. Screen the pregnant or postpartum member for behavioral health needs and make prompt and appropriate referrals.

Obstetrical Services

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

Sentara Health Plans' Medicaid program covers case management services for its high-risk pregnant women. Sentara Health Plans provides expanded prenatal care services to qualified members, including patient education; nutritional assessment, counseling, and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. Services are covered for 12 months after the pregnancy ends for all eligible members (excluding FAMIS birth members). In cases where the mother is discharged earlier than 48 hours after the day of delivery, at least one early discharge follow-up visit, indicated by the guidelines developed by ACOG, is covered. The early discharge follow-up visit is provided to all mothers who meet DMAS criteria, and the follow-up visit must be provided within 48 hours of discharge and meet minimum requirements.

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

Members may seek the following services at any participating health department or Planned Parenthood location or non-participating provider:

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

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

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

OB/GYNs are responsible for coordinating services with participating hospitals and specialists for OB-related care. The participating OB/GYN is responsible for notifying Sentara Health Plans' case management department for assistance with prenatal care and enrollment in the maternal health program.

Doula Services

Doulas are individuals based in the community who offer a broad set of nonclinical pregnancy-related services centered on continuous support to pregnant women throughout pregnancy and in the postpartum period. The doula recommendation form should be submitted before services begin.

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

- Childbirth education
- Lactation support
- Referrals for health or social services

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

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

Community-Based Doula Services

Sentara Health Plans has a designated contact and point person available to assist Doulas with all program activities (contracting, credentialing, billing, etc.).

Doula Qualifications and Referrals

Community-based doula services will be delivered by providers with training as outlined by DMAS and certified by the VDH or designated certifying board, which will designate qualifications and education requirements. Sentara Health Plans will only reimburse doulas who enroll as Medicaid providers, complete required Federal and State screenings, and who submit documentation requirements associated with the Medicaid provider enrollment process. Sentara Health Plans will use the DMAS issued doula recommendation form and will be billed directly by doulas for services, provided those services are referred by qualifying clinical professionals to include:

- Physicians
- Certified professional midwives
- Licensed midwives
- Nurse practitioners
- Physician assistants and
- Other Licensed Mental Health Professionals (LMHPs, physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, and certified psychiatric clinical nurse specialist).

Subsequent, Postpartum and Multiple Visit Doula Requirements

Sentara Health Plans will provide support for doulas to conduct up to 11 touchpoints with members.
These touchpoints:

a. Do not require service authorization.
b. Include 10 prenatal / postpartum visits in addition to one doula touchpoint for attendance at delivery.
c. Doula visits beyond the above visit limits may be authorized if medically necessary.
d. Visit limits apply to a doula-member pair. If a member receives care from more than one doula, each doula's visits to the member count only toward that individual doula's visit limit.
e. Doula services can only be provided in the community, clinician's offices (as in accompanying the member to a clinician visit) or in the hospital.

Subsequent prenatal visits:

f. Must be conducted at least one day after the doula's initial prenatal service visit, and no later than the date of delivery.
g. Up to three subsequent prenatal visits can be billed.
h. Attendance at delivery (vaginal or cesarean).

Postpartum Service visits:

i. Must be conducted no earlier than the date of delivery, and no later than 12 months after the date of the delivery.
j. Up to six postpartum visits can be billed.
k. Multiple visits are not allowed on the same day except when:
l. A prenatal doula visit occurs early in the day, and an attendance at delivery doula visit occurs later in the day.
m. Attendance at delivery doula visit occurs early in the day and a postpartum doula visit occurs later in the day.

Postpartum Coverage

Eligible Medicaid and FAMIS MOMS members can maintain their coverage for 12 months following pregnancy. This extension of benefits allows new parents to seek additional supportive services such as primary care, dental, and behavioral health services for one year to optimize health and health outcomes. Individuals enrolled in FAMIS Prenatal Coverage (PC) will receive the same comprehensive benefits as FAMIS MOMS throughout the pregnancy and birth, with a sixty (60) calendar day postpartum period under the FAMIS Prenatal Coverage (PC).

Medicaid Program Family Planning

Sentara Health Plans covers family planning services, which are defined as those services that delay or prevent pregnancy. Coverage of such services does not include treatments for infertility or services to promote fertility. Family planning services do not cover payment for abortion services, and no funds will be used to perform, assist, encourage, or make direct referrals for abortions. Coverage for induced abortions is only available in limited circumstances where a physician has found and certified in writing, that, based on their professional judgement, the life of the mother would be substantially endangered if the fetus were carried to term.

Sentara Health Plans covers family planning and contraceptive coverage, without the need for authorization, for members for all methods, including but not limited to barrier methods:

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

Sterilization Program

Sentara Health Plans Medicaid program covers these procedures at 100% for members age 21 and older. Medicaid program members must sign and submit a state-approved waiver at least 30 days before a procedure for sterilization services in accordance with Va. Code § 5.13.3.2. There must be documentation of the member being informed, the member giving written consent, and the interpreter, if applicable, has signed and dated the consent form prior to the procedure being performed.

Hysterectomies

Sentara Health Plans will not impose a 30-day waiting period for hysterectomies that are not performed for rendering sterility. Sentara Health Plans will inform the member that the hysterectomy will result in sterility and must have the patient acknowledge his or her understanding. Members undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization form (DMAS-3004) or adhere to the waiting period. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered.

Former Foster Care and Adoption Assistance

The Sentara Health Plans Medicaid program covers services for managed care enrolled former foster care and adoption assistance children. Coverage extends to all medically necessary EPSDT or required evaluation and treatment services of the foster care program. Sentara Health Plans coordinates with DSS and the members or adoptive parents in all areas of coordination. Former foster care and adoption assistance children are evaluated within a 60-day timeframe. Children should receive a PCP visit within 30 days of enrollment if they have not seen a provider within the 90 days prior to enrollment.

Immunizations/Vaccines

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

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

Medicaid program members, as appropriate to their age, are covered under the Virginia Vaccines for Children (VVFC) program. The VVFC program supplies vaccines to providers at no charge. The Sentara Health Plans Medicaid program will reimburse providers for the administration of the vaccine if the appropriate vaccine code is billed. **FAMIS does not participate with VVFC.** Immunizations provided to FAMIS members and eligible Medicaid program subpopulations should be billed using the appropriate CPT code to Sentara Health Plans.

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

Medicaid members 19 years of age or older are not eligible for the VVFC program. If vaccines are administered, reimbursement will be at the contracted fee.

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

All PCPs who administer childhood immunizations are encouraged to enroll in the VVFC, administered by the Virginia Department of Health (VDH). The process for VVFC provider enrollment is:

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

Hospice

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

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

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

Model of Care

The elements of the Model of Care 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 member's needs and preferences, and take into account member health safety and welfare
- Include staff and provider training
- 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

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 available by appointment
3. Personalized nutrition support from registered dietitians specializing in cancer care
4. An extensive library of clinically approved articles, videos, and virtual events

Care Management

Care management is locally and regionally based. Care managers are assigned to individual members to conduct care management activities in every region across Virginia and act as advocates for 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.

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.

Sentara Health Plans’ 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.

Person-centered Care Planning

Sentara Health Plans' approach to best practices for person-centered care planning, effective care transitions, and quality improvement is a core driver of program effectiveness and efficiency. These practices support individuals in living optimally in their preferred setting.

Person-centered Individualized Care Plan (ICP)

The care manager works with members to develop a comprehensive individualized care plan (ICP). Our Medicaid program uses a health risk assessment (HRA) as a tool to develop the member's person-centered ICP. The ICP is tailored to the members' needs and preferences and is based on the results of the program's risk stratification analysis. The ICP will be completed in conjunction with the HRA within the timeframe established by the member's severity and program, such as, high risk members will have an ICP within 7 days, moderate risk within 30 days, and low risk within 60 days of the HRA.

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 ICT member 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, built on the member's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

A Sentara Health Plans care manager will lead the ICT. The 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/specialist
- 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 of the following participants:

- Representative from the Medicare plan, if applicable

- Registered nurse
- Specialist clinician
- Other professional and support disciplines, including social workers, community health workers, and qualified peers
- Family members
- Other informal caregivers or supports
- Advocates
- State agency or other case managers

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 in order 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
    - 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

Reassessments

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

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 who are transitioning out of the child welfare system
- A child/youth who was adopted
- A youth who is transitioning to independence

To ensure continuity of care, Sentara Health Plans will:

- Conduct risk stratification to determine if a member may benefit from care management.
- Observe the continuity of care period for the first 30 calendar days of member's enrollment, 60 calendar days for high-intensity care management and pregnant members.
- Allow members to see 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 end of continuity of care period, except in the following circumstances:
    - member requests change
    - provider chooses to discontinue providing services to a member as currently allowed by Medicaid provider or Sentara Health Plans identifies performance issues that affect member's health or welfare
    - 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 TOC staff are available to help with transitions at the following facilities: Sentara Norfolk General, Sentara Virginia Beach General, and VCU Hospital.

Hospital/Ancillary

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

Hospital Payment Using Diagnosis Related Grouping (DRG) Methodology

If Sentara Health Plans has a contract with a facility to reimburse the facility for services rendered to its members based on a Diagnosis-Related Group (DRG) payment methodology, Sentara Health Plans will cover 100% of the full DRG inpatient medical hospitalization from time of admission to discharge while hospitalization remains medically necessary. This is effective for any actively enrolled member on the date of admission, regardless of whether the member is disenrolled during the inpatient hospitalization.

Sentara Health Plans covers provider services given during hospitalization for any date when the Sentara Health Plans Medicaid member was enrolled.

Emergency Room

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

Sentara Health Plans

Section V: Behavioral Health Services

Sentara Health Plans contracts with licensed mental health providers to provide an array of mental health and substance use services covered by Virginia Medicaid. For additional details regarding the services outlined in this section, please visit the DMAS website and review the mental health provider manuals located here.

*The chart below provides a partial listing of Outpatient Mental Health Services. For a comprehensive and up-to-date list, please refer to the DMAS website.

Outpatient Mental Health Services (MHS)

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

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

Mental Health Services Authorizations/Registrations

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

MHS requires authorization or registration before initiating services. For a complete listing of services that require/do not require authorization, refer to the online 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. Refer to the "Sentara

Health Plans Key Contact Information" section for fax numbers. Providers should expect a standard turnaround time on all requests within 14 calendar days. Urgent requests can be turned around within three calendar days or 72 hours of receipt.

The provider 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 on the Sentara Health Plans provider website and the DMAS website.

Behavioral Health Resident in Training and Supervisees

Residents in counseling and supervisees in social work practice under the license of their clinical supervisor. They can work with all populations for which their supervisor is credentialed. The supervisor shall assume full responsibility for the clinical activities of the board-approved resident, regardless if the supervisor is on-site or off-site, specified within the supervisory contract (application) for the duration of the residency.

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

Billing for these services must be submitted 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 the Department of Medical Assistance Services (DMAS) behavioral fee-for-service (FFS) contractor. Youth who are admitted to a Psychiatric Residential Treatment Facility remain enrolled in their Medicaid Managed Care Organization (MCO) during their stay. While the PRTF per diem is paid by DMAS through the fee-for-service program, ancillary services outside the per diem—such as physician services, dental and pharmacy services—are covered by the member's Managed Care Organization.

Youth in PRTFs will have an assigned MCO care manager who will assist to coordinate non-PRTF services as well as behavioral health services at discharge. In collaboration with the MCO care manager, the PRTF will maintain primary responsibility for arranging necessary services while the individual is in the facility and for discharge planning. Service authorization and Independent Assessment Certification and Coordination Team (IACCT) assessments for PRTF services continue to be managed by the DMAS fee-for-service contractor.

Members admitted to a Therapeutic Group Home are not excluded from the Medicaid managed care program. TGH services are authorized through the DMAS service authorization coordinator. While a member resides in a TGH, Sentara Health Plans collaborates with DMAS and the fee-for-service contractor to coordinate care and continues to provide coverage for transportation and pharmacy services.

For members admitted to residential treatment centers for substance use disorder (SUD), all services remain covered under the Sentara Health Plans' Medicaid Managed Care Organization program. These members continue to receive both residential and ancillary services through their MCO benefit.

Addiction and Recovery Treatment Services (ARTS)

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

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

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

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

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

Additional information for ARTS services, including authorizations, provider requirements, covered services and utilization review, and controls, can be found in the DMAS ARTS Manual.

Disclosure of Protected Health Information

Federal law (42 CFR Part 2) requires federally assisted alcohol or drug use treatment providers to protect members from being identified as having a substance use disorder or as participants in a covered treatment program without their written consent. Except in limited circumstances, the law requires a patient's consent for disclosure of patient information protected by 42 CFR Part 2, even for treatment, payment, or healthcare operations.

Providers can consult their legal counsel for more information regarding this requirement.

Provider Participation Requirements

Addiction and Recovery Treatment Services (ARTS) providers must be qualified as defined in the ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine, DMAS regulations, and the most current version of the DMAS ARTS Provider Manual. To participate in the Sentara Health Plans Medicaid program, providers must be credentialed and contracted by DMAS and Sentara Health Plans in addition to being enrolled in the Department of Medical Assistance Services (DMAS) PRSS Portal. Providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) and registered with the Department of Health Professions (DHP). These providers include:

- Opioid treatment programs
- Office-based opioid treatment
- Case management
- Peer recovery supports
- Inpatient detox
- Residential treatment
- Partial hospitalization
- Intensive outpatient programs

ARTS Service Authorization and Registration

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

For initial requests, providers should complete the ARTS Service Authorization Review Form.

To request an extension for the same ASAM level, providers should complete the ARTS Service Authorization Extension Review Form. These forms are available on the Sentara Health Plans provider website and the DMAS website.

Providers submitting ARTS Registration Requests should fax the completed forms to Sentara Health Plans at 1-844-348-3719. Providers will be notified of approvals/adverse decisions via fax and/or letter. All ARTS requests will be reviewed within 72 hours of receipt. Requests for

service authorizations that do not meet the ASAM requirements for the requested level of care will not be approved.

Contracting and Credentialing

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

- A completed 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

Please reference the chapters of the DMAS Provider Manuals addressing DMAS Billing Instructions, and appendices for specific service for information on billings and provision of units.

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

Telemedicine

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

Transportation

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

Continuity of Care

If a member's Medicaid plan changes while receiving services, members may maintain their current MHS provider for up to 30 days (or 60 days for members receiving high intensity care management). Service authorizations issued prior to Sentara Health Plans Medicaid program enrollment will remain for the service authorization or duration of the 30-day continuity of care period; whichever comes first. Authorizations will be extended as necessary to ensure a safe and effective transition to a qualified in-network provider. DMAS has sole discretion to extend the continuity of care period timeframe.

Behavioral Health Out-of-Plan Authorizations

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

Sentara Health Plans

Section VI: Health and Preventative Services

Member Services

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

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

- **Birthday Cards** – Plan members receive a birthday card during their birth month from Sentara Health Plans.
- **Healthy Pregnancy Mailings** - Once the health plan learns of a member's pregnancy, the member receives communication (or materials) 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 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 employees. 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 download programs on-demand or place an order for materials to be delivered via U.S. mail. 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 desktop, 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

Members' wellness portal dashboards feature a dynamic display highlighting articles, resources, and personalized recommendations based on the information they have provided. For instance, if they have identified a goal or issue related to stress, they will see content related to stress management, or if they 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, Fitbit, Garmin, iHealth, Jawbone, Life Fitness, Medisana, Microsoft, Misfit, Moveable, Nokia, 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 improving their health. The program includes a wireless smart scale, weekly online lessons, professional health coaching, and small online peer groups that offer real-time support. Members can determine if they qualify for the program by visiting Omada and completing the online screening tool.

Sentara Health Plans

Resources

We offer several resource libraries that host up-to-date information to help answer member 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 news and current preventive health initiatives to the Sentara Health Plans provider newsletter and other Sentara Health Plans publications.

Sentara Health Plans

Section VII: Covered Services

Enhanced Benefits

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

Hearing Aid Services

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

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

Members can access their benefits information by visiting this link or by calling NationsBenefits, LLC at 1-844-376-8637. Member experience advisors are available 24 hours per day, seven days per week, 365 days per year. Language support services are available free of charge.

Brain Injury Services (BIS) Case Management

BIS case management services are activities designed to assist individuals eligible under the State Plan who reside in a community or institutional setting, in gaining access to needed medical, social, educational, and other services as planned upon discharge from a facility or while residing in the community. Case management does not include the provision of direct clinical or treatment services. Regulations and guidance from DMAS are pending.

Chiropractic

Sentara Health Plans only covers chiropractic services when medically necessary in accordance with EPSDT criteria. FAMIS members have coverage up to a certain dollar limit each calendar year for medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.

Dental

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

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is a benefit described in the Social Security Act § 1905(a) and 12VAC30-130-5040 to correct or ameliorate defects and physical and mental illnesses and conditions, including substance use disorder, discovered by the screening. All medically necessary EPSDT services for members under age 21 are covered. Sentara Health Plans complies with EPSDT requirements, including providing coverage for all medically necessary services for children needed to correct, ameliorate, or maintain health status.

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

- Extended behavioral health benefits
- Nursing care (including private duty)
- Personal care
- Pharmacy services
- Treatment of obesity
- Neurobehavioral treatment
- Other individualized treatments specific to developmental issues

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

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

EPSDT Documentation Requirements

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

- The medical record must indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT-related services, whether provided by the PCP or another provider.
- Documentation of a comprehensive screening must, at a minimum, contain a description of the components utilized.
- The medical record must indicate when a developmental delay has been identified by the provider and an appropriate referral has been made.

EPSDT Screenings

EPSDT medical screenings must include:

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

EPSDT Treatment and Referrals

Sentara Health Plans monitors provider compliance with the required EPSDT activities. Providers are required to promptly notify Sentara Health Plans if a screening for a member eligible for services under EPSDT reveals the need for other health care services and the provider is unable to make an appropriate referral. Upon notification of the inability of a provider to make an appropriate referral for EPSDT services, Sentara Health Plans will secure the referral and assist the member with scheduling and transportation, if needed.

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

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

If the family requests assistance with transportation and scheduling to receive services for early intervention, Sentara Health Plans will provide this assistance.

Early Intervention (EI) Services

EI services are covered for children from birth to age three who have:

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

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

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

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

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

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

- Ensure the member receives the necessary EI services timely and in accordance with federal and state regulations and guidelines.
- Coordinate other services needed by the member.
- Transition the member to appropriate services.

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

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

Medical Supplies and Medical Nutrition

Medical supplies and equipment are covered to the extent allowed by DMAS if they are prescribed by a practitioner. There are no maximum benefit limits on durable medical equipment (DME), however, DME benefits are limited based upon medical necessity. Use beyond DMAS-established limits must be medically necessary. Additional documentation may be necessary to justify amounts, types, and duration of use beyond the limits set by DMAS. Nutritional supplements and supplies are covered benefits. The Sentara Health Plans Medicaid program covers specially manufactured DME that was pre-authorized, per DMAS requirements. Please review the current Summary of Benefits or contact member services for service authorization requirements.

Additional information can be found in the Durable Medical Equipment and Supplies Provider Manual available on the DMAS web portal found here.

Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services

The Sentara Health Plans Medicaid program must provide physical therapy, occupational therapy, speech pathology, and audiology services in inpatient settings, outpatient hospital services, outpatient rehabilitation agencies, or through home health services. Benefits include coverage for acute and non-acute conditions and may be limited based upon medical necessity. There are no maximum benefit limits on medically necessary PT, OT, SLP, and audiology services. These services are covered, regardless of where they are provided.

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

Preventive Care

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

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

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

Private Duty Nursing (PDN)

Sentara Health Plans covers medically necessary PDN services for children under age 21, consistent with the DMAS criteria described in the DMAS EPSDT Nursing Supplement, and for members over age 21 in the technology dependent subgroup who have serious medical conditions and complex health care needs. Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing, which provides short-term, intermittent care where the emphasis is on member or caregiver teaching. Under EPSDT PDN, the individual's condition must warrant continuous nursing care, including but not limited to nursing-level assessment, monitoring, and skilled interventions.

Prosthetic Devices

Prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) are covered benefits under Medicaid. Sentara Health Plans covers Medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.

Transplants

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

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

Vision Coverage

Preventive vision services are not reimbursed under the medical plan and should be obtained by members through the Sentara Health Plans vision vendor.

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

Long-term Services and Supports

Long-term Services and Supports (LTSS) are provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional settings.

The LTSS program:

- Provides comprehensive care management that integrates the medical, behavioral health, and social models of care through a person-centered approach.
- Promotes member choice and rights.
- Engages the member and family members throughout the process.
- Prioritizes continuity of care and seamless transitions, for members and providers, across the full continuum of physical health, behavioral health, and LTSS benefits.

LTSS Service Authorization

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

To receive LTSS, the member's condition must first be evaluated using the designated assessment instrument, the Uniform Assessment Instrument (UAI), and other DMAS-designated forms. LTSS-screening teams must use DMAS-designated forms. If necessary based on the evaluation, a member may be referred to the Department of Behavioral Health and Developmental Services (DBHDS) for evaluation and determination prior to admission to a nursing facility. All members receiving LTSS must meet the criteria established by DMAS via its regulations, guidance, and provider manuals.

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

Patient Pay for LTSS

Patient Pay refers to the member's obligation to pay towards the cost of LTSS, if the member's income exceeds certain thresholds. Patient Pay, which is calculated by the Department of Social Services (DSS), is different and should not be confused with a copay, deductible, or coinsurance. Patient pay is required to be calculated for every individual receiving nursing facility or waiver services unless it is not required based on eligibility category. Not every eligible individual will acquire a patient pay liability. When a member's income exceeds an allowable amount, they must contribute toward the cost of their LTSS.

Waivers

DMAS operates two types of waivers: the CCC Plus HCBS Waiver and the DD Waivers.

Commonwealth Coordinated Care (CCC) Plus Waiver

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

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

Developmental Disability (DD) Waiver

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

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

Nursing Facility (NF) and Long-Stay Hospital Services

The Sentara Health Plans Medicaid program covers skilled and intermediate NF care for Medicaid program members, including for dual-eligible members after the member exhausts their Medicare-covered days. Sentara Health Plans will pay NFs directly for services rendered.

Sentara Health Plans works with NFs to:

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

NFs must cooperate with the Sentara Health Plans Medicaid program for Sentara Health Plans representatives to attend (either in person or via teleconference) all care plan meetings for Medicaid program members who are receiving NF services. Attendance at the care plan meetings will ensure that the NF is current with the care needs of the members and will provide access to Sentara Health Plans to discuss service options.

Trauma-Informed Care

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma and adverse childhood experiences have played in their lives. This approach builds on member resiliency and strengths to address the physical and emotional well-being of the individual.

Telemedicine and Telehealth

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

Telehealth refers to a broader scope of remote healthcare services than telemedicine and includes the use of telecommunications and information technology for health assessment, diagnosis, intervention, consultation, supervision, and information sharing across distances. Telehealth includes such technologies such as telephones, facsimile machines, electronic mail systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Remote patient monitoring (RPM) is defined as the use of digital technologies to collect medical and other forms of health data from patients in one location and electronically transmit that information securely to health providers in a different location for analysis, interpretation, recommendation, and management of a patient with a chronic or acute health illness or condition. These services include monitoring of clinical patient data 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 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), 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), including 2024 amendments to Virginia Code § 32.1-325 requiring remote ultrasound procedures and remote fetal non-stress tests; including for high-risk pregnant patients with maternal diabetes and maternal hypertension.
- 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 members' 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 Model of Care requirements.

Carved Out Services

The following services are carved out of the contract between Sentara Health Plans and DMAS. These services are reimbursed directly to providers by DMAS on a fee-for-service basis:

- Dental and related services.
- Local education agency-based services are covered services rendered by service providers who are employed or contracted by a local education agency, and the local education agency is the billing provider of those services.
- Services provided through tribal clinic providers.
- Developmental Disabilities (DD) Waiver services (including when covered under EPSDT) such as targeted DD case management, and transportation to/from DD Waiver services (nonwaiver services are included in the Medicaid program).
- Independent Assessment, Certification, and Coordination Team (IACCT)
- Psychiatric residential treatment facility services (PRTF).
- Therapeutic group home (formerly level A and B group home).
- Treatment foster care - case management.

Sentara Health Plans

Section VIII: Pharmacy

Pharmacists as Providers

In accordance with the provisions of § 54.1-3303.1, Virginia law allows pharmacists to initiate treatment with, dispense, or administer certain drugs and devices to Medicaid program members 18 years of age or older with whom the pharmacist has a bona fide pharmacist-patient relationship in accordance with a statewide protocol developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health and set forth in regulations of the Board.

Pharmacists who initiate treatment with, dispense, or administer a drug or device in accordance with state law shall counsel members regarding the benefits of establishing a relationship with a primary health care provider.

To provide medical services, pharmacists must meet PRSS enrollment requirements in addition to meeting Sentara Health Plans contracting and credentialing requirements. Pharmacists acting as providers are also responsible for adherence to the State Board of Pharmacy protocols. This includes obtaining the appropriate training and maintenance of records.

Pharmacists can find additional information on the contracting, credentialing, and billing processes by visiting the Sentara Health Plans provider website, which can be found at this link.

Prescription Drug Coverage

Sentara Health Plans covers 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 in 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 listing covers non-Part D medications as well as some select OTC coverage. The DMAS PDL is not an all-inclusive list of drugs. The Medicaid program will cover all medically necessary, clinically appropriate, and cost-effective drugs that are federally reimbursable.

Drugs not listed on the PDL may be rejected at the pharmacy unless Sentara Health Plans has approved a medical necessity request, and an override is put into the system. Sentara Health Plans' Medical Necessity Request Form is available on the provider website or by contacting the pharmacy department by phone at 1-800-229-8822, Monday through Friday, 8 a.m. to 6 p.m.

Medical Necessity Request Forms should be faxed to the pharmacy department at 1-800-750-9692.

OTC medications that are covered on the DMAS PDL will require a prescription to process at the pharmacy.

Drugs on the PDL may be subject to edits such as 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 at virginiamedicaidpharmacyservices.com/provider/documents/

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

Service Authorization Process

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

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

All requests will be processed, and a response 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 a request for service authorization.

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

Emergency Supply

Members will be eligible for a 72-hour emergency supply of a prescribed medication in an instance where the medication requires a service authorization, or the prescribing provider cannot readily provide an authorization, 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 HCPC code. This requirement applies to both UB and HCFA claims. The most current NDC numbers are available from the FDA's NDC Directory or the RJ Health Systems listing.

NDC Number Requirements:

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

Quantity:

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

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

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

Coverage of Contraceptives

Medicaid program provides coverage for members for all methods of family planning, including but not limited to:

- Barrier methods
- Oral contraceptives
- Vaginal rings
- Contraceptive patches
- Long-acting reversible contraceptives (LARCs) - members are free to choose the method of family planning. 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 (MTM)

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 ARTS section of this provider manual.

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Specialty Drugs

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

Specialty drugs may include:

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

For more information on how to obtain specialty drugs for your patients, please call pharmacy services at 1-800-229-8822, Monday through Friday, 8 a.m. to 6 p.m.

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 every day.

Sentara Health Plans' network and affiliated providers are required to comply with the health plan's Quality Improvement (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 voluntarily participates in the accreditation process administered by the National Committee for Quality Assurance (NCQA). NCQA is a private, nonprofit organization dedicated to improving healthcare quality. NCQA accredits and certifies a wide range of healthcare organizations. It also recognizes clinicians and practices in key areas of performance. NCQA is committed to providing healthcare quality information for consumers, purchasers, healthcare providers, and researchers.

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

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 field
- 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 DSS, DOH, DHP, 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 (QI) Program

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

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. 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 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.

The primary objective of Sentara Health Plans' QI Program is to continuously improve the quality of care provided to enhance the members' overall health status. 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 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 a "healthcare-acquired condition" (HAC) or an "other provider-preventable condition" including, but not limited to:

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

Serious Reportable Events (SREs)

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
- Any mental health services provider as defined in § 54.1 -2400.1
- Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5, 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
- Any guardian or conservator of an adult
- Any person employed by, or contracted with, a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity

Procedures/Guidelines

Sentara Health Plans requires all network and/or affiliated providers to report critical incidents within 24 hours of discovery via the approved 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. Sentara Health Plans contact information to report a critical incident is located on the DMAS Critical Incident Reporting Form located under "Forms" or the Sentara Health Plans Key Contact Information 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 could 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 our credential verification, quality assurance, risk, or utilization management programs regulations can lead to exclusion from federal funding, including payments from Medicare and Medicaid, as well as criminal and civil liability.

Quality Management Review (QMR) Waiver Services

In accordance with federal regulations, specifically Title 42 of the Code of Federal Regulations (CFR), Parts 455 and 456, the Virginia State Agency 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 Virginia State Agency Waiver Program's policies, procedures, and regulatory standards. QMRs may be conducted directly by the Virginia State Agency or through its designated agents.

At the direction of the Virginia State Agency, 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
- 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 the Virginia State Agency requirements or for confirmed instances of fraud, waste, or abuse

As part of the Quality Management Review (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 the Virginia State Agency 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 Virginia State Agency's 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, Virginia State Agency 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 (EFT)

EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 48 hours after payments are processed. Clean claims are processed and paid for by Sentara Health Plans within an average of seven days when submitted electronically and when payment is made through EFT. For Medicaid program claims, EFT and 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 zelis.com/providers/provider-enrollment/.

Sentara Health Plans ePayment Center

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

Paper Claims

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

Common Reasons for Claim Rejection

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

Remittance Advice

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

Coordination of Benefits (COB)

Sentara Health Plans Medicaid program members who are covered by employer-sponsored health plans may be enrolled in a Medicaid-managed care plan. 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. Sentara Health Plans will coordinate benefits.

For children with commercial insurance coverage, providers must bill the commercial insurance plan first for covered early intervention services, except for the following:

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, the Sentara Health Plans Medicaid program requires the early intervention provider to complete the notification to DMAS under the following circumstance:

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

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 provider portal under the resources tab in Payer Spaces. The policies explain acceptable billing and coding practices to equip providers with information for accurate claims submission. Sentara Health Plans will inform providers as new policies are published. To access the policies, providers must have an active Availity Essentials provider portal account.

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 with 30 days advance notice to the provider stating the reason for the retraction. If retraction is not possible and the provider would prefer to send a refund, please send a copy of the remit, the reason the claim was paid in error, and the payment check within 30 days to the Sentara Health Plans provider refunds address in the “Sentara Health Plans Key Contact Information” section of this manual.

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

Treatment of Recoveries

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 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 the 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, including substance use disorder (SUD) services. For a listing of codes that are known to be non-covered and would be considered bypass claims, please refer to the latest DMAS guidelines.

Hospital/Ancillary Billing Information

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

Sentara Health Plans will group 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.

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

Inpatient claim coding must follow "most current" coding based on the date of discharge. If codes become effective on a date after the member's admission date but before the member's discharge date, Sentara Health Plans recognizes, and processes claims, with codes that were

valid on the member's date of discharge. If the hospital agreement terms change during the member's inpatient stay, payment is based on the hospital agreement in effect at the date of discharge. If the members' benefits change during an inpatient stay, payment is based upon the benefit in effect on the date of discharge. If a member's coverage ends during the stay, coverage ends on the date of discharge.

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

Pre-admission Testing

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

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

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

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

Readmissions

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 defined as a "never event" for a member existed prior to the initiation of treatment for that member. Reductions in reimbursement may be limited to the extent that the following apply:

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

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

When an inpatient claim is denied as a “never event”, all provider claims associated with that “never event” will be denied. In accordance with CMS guidelines, any provider in the operating room when 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 ten days, and then readmitted under the same authorization. Examples include situations in which surgery could not be scheduled immediately, a specific surgical team was not available, or further treatment is indicated following diagnostic tests but cannot begin immediately.

Interim Billing

Interim billing indicates that a series of claims may be received for the same confinement or course of inpatient treatment that spans more than thirty (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 a 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), and the party responsible for the charges.

Facility Outpatient Services

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

Outpatient facility services typically have a member cost-share. Sentara Health Plans assigns certain revenue codes to specific plan benefits. For example, revenue codes 0450–0459 are mapped to emergency department services and further drive the determination of the member’s cost share. The default outpatient benefit is “outpatient diagnostic.” Member cost-share may be waived if the member is subsequently admitted.

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

Laboratory Services

Sentara Health Plans’ reference lab providers are required to provide an electronic report each month. This report includes actual test values for selected tests used by Sentara Health Plans in HEDIS® reporting and in disease management. Laboratory provider service standards and reporting requirements are listed in the Reference Laboratory Provider Agreement.

Emergency and Post-Stabilization Services

Sentara Health Plans must cover and pay for emergency and post-stabilization care services in accordance with the federal standards at 42 U.S.C. § 1396u-2(b)(2), 42 CFR §438.114, 42 CFR §422.113(c), and Section 1852(d)(2) of the Social Security Act, and in compliance with mental

health parity rules per 42 CFR §438.910. Sentara Health Plans must cover emergency services without a service authorization.

Payment of Emergency Services

Sentara Health Plans defines “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 abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- 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:

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

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

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

Sentara Health Plans cannot not limit what constitutes an emergency medical condition or behavioral health condition on the basis of lists of diagnoses or symptoms nor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, 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 §422.113(c)(3) 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
- The member is discharged

Sleep Studies

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

Electronic Visit Verification (EVV) for Home Health Provider

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

- Type of service(s) performed

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

EDI General Overview

All Sentara Health Plans Companion Guides are to be used with the HIPAA-AS Implementation Guide. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) implementation guides provide comprehensive information needed to create each ANSI transaction set. The Sentara Health Plans Companion Guide is used in conjunction with the HIPAA Implementation Guide: it is intended to clarify issues where the HIPAA Implementation Guide provides options or choices to be made. The HIPAA Implementation Guide is available from the Washington Publishing Company.

EDI Business Use

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

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

- The 835-transaction file consists of a separate remittance file (ERA) and a separate electronic funds file (EFT).

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

340B Registered Entities

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

Dispute Resolution

Subject to the exceptions noted below, any dispute initiated by the provider arising out of or relating in any manner to the Provider Agreement, whether sounding in tort, contract, or under statute (a “Provider Dispute”) shall first be addressed by exhausting all Policies and Procedures applicable to the Provider Dispute before a provider may seek to resolve the Provider Dispute in any other forum or manner. Policies and Procedures shall include the following: Program Integrity Audit, Reconsideration and Appeals Policy; Provider Appeals Procedure; Credentialing/Recredentialing Appeals Process; and Appeals of an Adverse Benefit Determination Policy. If the Provider Dispute is of a type not subject to the Policies and Procedures, the provider and Sentara Health Plans shall engage in good faith negotiations between their designated representatives (such representatives shall be authorized to resolve the dispute). The provider must initiate negotiations upon written request to 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 (2) 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 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: 1-844-434-2916

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 the independent external quality review organization within 30 days of the final internal appeal decision. External review requests from FAMIS members or their authorized representative should be sent in one of the following ways:

- Online: https://dmas.kepro.com by clicking the external appeal link.
- Mail to:
  Acentra/KEPRO External Review
  6802 Paragon Place, Suite 440
  Richmond, VA 23230

The FAMIS member may also request a state fair hearing from DMAS within 120 days of the final internal appeal decision. Please see the state fair hearing information below.

State Fair Hearing

If the member disagrees with the internal appeal decision, they may appeal directly to DMAS by submitting a request for a state fair hearing. The appeals process above must be exhausted before the member, member's attorney, or member's authorized representative may submit a request for a state fair hearing. DMAS will resolve a standard request within 90 days and an expedited request within 72 hours.

The 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 for members 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 1-804-371-8488 (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 may be able to continue the services that are scheduled to end or be reduced if they ask for an appeal within 10 days of the later of: (i) the date Sentara Health Plans sends 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 filling 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 Plans 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.

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 & Responsibilities

General Member Rights and Responsibilities can be found on the Sentara Health Plans website located here.

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

If the member or someone they know is being abused, neglected, or financially taken advantage of, they can call their local DSS or Virginia DSS at 1-888-832-3858. This call is free.

General Member Responsibilities

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

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 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. The disclosure includes:

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

A nursing facility must disclose upon initial enrollment and 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.

Code of Conduct

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

- Treat members with respect and dignity
- Deal openly and honestly with fellow employees, members, providers, representatives, agents, governmental entities, and others
- Adhere to federal and state laws, regulations, and Sentara Health Plans policies and procedures in all business and personal dealings, whether at work or outside of work

- Exercise discretion in the processing of claims, regardless of provider, practitioner, and vendor source
- Notify and return overpayments to Sentara Health Plans immediately upon receipt of such payments and in no event no later than 60 days from the date on which the overpayment was identified in accordance with 42 CFR § 438.608. Providers must also notify Sentara Health Plans in writing of the reason for overpayment
- Notify Sentara Health Plans' compliance officer of any instances of noncompliance and cooperate with all investigational efforts by Sentara Health Plans and other state and federal agencies
- Use supplies and services in an efficient manner to reduce costs for Sentara Health Plans
- Do not misuse Sentara Health Plans' resources nor influence in such a way as to discredit the reputation of Sentara Health Plans
- Maintain high standards of business and ethical conduct in accordance with regulatory and accredited agencies to include standards of business to address fraud, waste, and abuse
- Practice good faith in transactions occurring during business
- Conduct business dealings in a manner that the organization shall be the beneficiary of such dealings
- Preserve patient confidentiality, unless there is written permission to divulge information, except as required by law
- Refuse any illegal offers, solicitations, payment, or other enumeration to induce referrals of the members we serve for an item of service reimbursable by a third party
- Disclose financial interest/affiliations with outside entities to Sentara Health Plans, as required by the Conflict of Interest Statement
- Hold all contracted parties to the same Standards of Professional Conduct as part of their dealings with Sentara Health Plans
- Providers providing services to CCC Plus Waiver members shall comply with the provider requirements, as established in the DMAS provider manuals available at vamedicaid.dmas.virginia.gov/provider/faq and the following regulations: 12 VAC 30-120-900 through 12 VAC 30-120-995
- Providers of CCC Plus Waiver services (including adult day healthcare) shall maintain compliance with the provisions of the CMS Home and Community-based Settings Rule, as detailed in 42 CFR §441.301(c)(4) and (5)

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.

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.

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 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).

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.

All office 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 Part 2.

Medical Record Documentation Standards

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.

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 no more than 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

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 state agency 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 the relevant state statutes.

Monitoring the Quality of Care

Sentara Health Plans collaborates with contracted network and/or 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 exists, 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, especially patients seen three or more times, 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 phone call follow-up 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 laws. 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 for Virginia and North Carolina providers 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 (5) 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.

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Sentara Health Plans

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 at this link
- 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 Availity and other secure provider portals

Sentara Health Plans Network Management

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

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

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

Provider Portal

Effective January 1, 2024, Sentara Health Plans 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 2025 and 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

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

Quarterly Provider Newsletter

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

Medical Policy Updates

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

Provider Collaboration

In accordance with NCQA requirements, Sentara Health Plans maintains a Provider Leadership Committee (PLC), which includes external network providers that are representative of the specialties in the network and Sentara Health Plans clinical and network management members. At least two providers on the committee must maintain practices that predominantly serve Medicaid members and other indigent populations, in addition to at least one other participating provider on the committee who has experience and expertise in serving members with special needs. The Sentara Health Plans PLC meets virtually bi-monthly to function as an advisory body and assists in obtaining essential feedback about preventive health practices. The PLC makes recommendations for innovations or revisions in existing services to better meet the needs of Sentara Health Plans members. Input and recommendations from the PLC

inform and direct our quality improvement activities as well as guidelines, policy, and operational changes.

Changes to the Provider Manual

Notice of changes, amendments, and updates to this Provider Manual and any sources that are referenced by and incorporated herein are communicated to providers via the Sentara Health Plans website and by email (for providers who have notified Sentara Health Plans of their email address) 60 days before the changes become effective. Therefore, it is important to inform Sentara Health Plans of mailing and email address changes by submitting a Provider Update Form. Check the provider website often for changes and monitor email notifications.

Provider Webinars

Online educational webinars are held and allow Sentara Health Plans the opportunity to answer questions from providers, share updates, and offer ideas on how to successfully do business with Sentara Health Plans. Providers must register on the Sentara Health Plans provider website by the day before each event. The events are announced here and in the provider alert email, along with other educational opportunities.

Encouraged Education and Trainings

Providers can access both required and encouraged trainings here.

All providers within a provider practice or organization are required to review the 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 sent to Sentara Health Plans and can be obtained by accessing this link. If there are multiple providers in a Provider practice or organization, only one attestation is required per Tax ID. The attestation must be received and verified by Sentara Health Plans. Once an attestation is received and on file, 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.

Trauma-informed Care Training

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

Provider Satisfaction Surveys

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

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 network educator.

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 plan 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 mechanisms that will ensure compliance with timely access to care, and the services standards described below. Sentara Health Plans monitors network providers for compliance with these appointment timeliness standards on an ongoing basis, including monitoring Grievances and Appeals data for indications that problems may exist with access to specific providers or provider types. Sentara Health Plans will take corrective action if there is a failure to comply with a network provider.

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

Service Type	Sentara Health Plans Medicaid Standards
Emergency Services, including 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 48 hours of the member's request
Regular and 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 Care 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 provisions of the state Boards of Medicine and Nursing licensure.

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 – meaning 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 Plans' 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 fraud, waste, and abuse by implementing an Anti-fraud Plan to ensure compliance with state and federal regulations.

Providers may read more about Sentara Health Plans' Anti-Fraud Plan.

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 Program Integrity Unit (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 abuse treatment Information is

limited to information necessary for the subcontractor to perform services they are obligated to perform under its agreement.

Business Information

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

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

Anti-Kickback 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, inspector general, or the Department of Justice if the contractor has reasonable grounds to believe that a violation exists.

Business Records

Sentara Health Plans' 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.

Whistleblowers

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

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

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.

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.