Sentara®
Health Plans

Doing Business With Sentara Health Plans

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Purpose of the Guide

This guide is designed to orient providers on best practices to successfully conduct business with Sentara Health Plans.

Note: The **Sentara Health Plans Provider Manual**—a more extensive resource—is your trusted source for the health plan's policies and procedures.

PRSS Enrollment

All Medicaid managed care network providers must enroll through Provider Services Solution (PRSS) to satisfy and comply with federal requirements in the 21st Century Cures Act.

Main points:

- From **virginia.hppcloud.com/**, go to "Menu," then "Provider Enrollment," and select either "New Enrollment" or "Enrollment Status."
- Only one enrollment application is necessary in PRSS, even if you participate with more than one managed care organization (MCO).
- In order to be a Medicaid provider in an MCO's network, providers must first enroll through PRSS and then contact the MCO(s) you wish to participate in to ensure each MCO's requirements are satisfied.

Member Rights

The Member Rights and Responsibilities document assures that all Sentara Health Plans members are treated in a manner consistent with our mission, goals, and objectives. The Member Rights and Responsibilities ensure that members are aware of their obligations and responsibilities upon joining Sentara Health Plans and throughout their membership with us. Each Sentara Health Plans product has specific Member Rights and Responsibilities and members are mailed information on where to locate their Rights and Responsibilities at the time of enrollment.

The Member Rights and Responsibilities are similar for all Sentara Health Plans products but have slight variations based on the product and its membership.

- The Sentara Health Plans commercial (HMO/POS/PPO/Individual) product **Member Rights and Responsibilities**.
- The Sentara Health Plans Medicaid product **Member Rights and Responsibilities** can be found in our Medicaid Provider Manual on page 84.
- The Sentara Health Plans Medicare product **Member Rights and Responsibilities** can be found in our Medicare HMO Provider Manual on page 7.

Health Plan Obligations

Sentara Health Plans obligations are found in your provider agreement.

Provider Obligations

Provider obligations are found in your provider agreement.

Reimbursement for Services Rendered While Credentialing is Pending for Commercial Plans

According to VA Law § 38.2-3407.10:1 of the Code of Virginia, Sentara Health Plans may reimburse providers for services rendered during the period in which their credentialing application is pending. An application is considered pending once the application has been deemed complete/clean by Sentara Health Plans to advance within the credentialing process. Reimbursement for services rendered during the pending application period is contingent upon approval of the provider's credentialing application by Sentara Health Plans credentialing committee and subsequent provider record configuration in the Sentara Health Plans claims system. However, no services shall be provided to a Sentara Health Plans member until a completed credentialing application has been received by Sentara Health Plans. Claims for these services must be held until the provider has received notification of credentialing approval and the provider agreement is signed by Sentara Health Plans. The Provider agreement must be fully executed for the claims to be processed. If a Sentara Health Plans provider agreement is not signed and/or the provider does not meet all credentialing requirements, Sentara Health Plans is not required to reimburse claims as a network provider and the provider should not seek any reimbursement for services provided to the member from the time of application to final notice of the credentialing decision.

To submit claims to Sentara Health Plans, pursuant to the law, new provider applicants shall provide written or electronic notice to covered members in advance of treatment that they have submitted a credentialing application to Sentara Health Plans stating it is in the process of obtaining approval. More information on the recommendations on what to include in the notice can be found in our **Sentara Health Plans Credentialing Guide**. If a payment is made by Sentara Health Plans to a new provider applicant or any entity that employs or engages such new provider applicant under this section for a covered service, the patient shall only be responsible for any coinsurance, copayments, or deductibles permitted under the insurance contract with the carrier or participating provider agreement with the physician, mental health professional, or other provider. If the new provider applicant is not credentialed by the carrier, the new provider applicant or any entity that employs or engages such physician, mental health professional, or other provider shall not collect any amount from the patient for health care services or mental health services provided from the date the completed credentialing application was submitted to Sentara Health Plans until the applicant received notification from Sentara Health Plans that credentialing was denied.

Credentialing Overview

The information below is a summary of the standard Sentara Health Plans credentialing process. The goals of the Sentara Health Plans credentialing/recredentialing policy are to promote professional competency and to protect:

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

Scope

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

Recredentialing

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

***For full explanation please review the Sentara Health Plans Commercial and Medicare Provider Manual and the Sentara Health Plans Medicaid Provider Manual.*

Provider Access and Member Care

Access to Care

Access to care is recognized as a key component of quality care. As a condition of participation, providers must provide covered services to members on a 24-hour per day, 7-day per week basis, in accordance with Sentara Health Plans' standards for provider accessibility. This includes, if applicable, call coverage or other backup, or providers can arrange with an in-network provider to cover patients in the provider's absence. Providers may direct the member to go to an emergency department for potentially

emergent conditions, and this may be done via a recorded message.

Appointment Access Standards–Medicaid

Service	Sentara Health Plans Medicaid Standards
Emergency Services, Including Crisis Services (Medical and Behavioral Health)	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request. Follow-up to crisis services must be made within 24 hours of Sentara Health Plans being notified of the crisis services utilization.
Non-life-threatening Behavioral Health Emergency	Within six hours or directed to emergency care.
Urgent Appointments (Medical and Behvioral Health)	Within 24 hours of the member's request.
Regular and Routine Primary Care Services	Regular and Routine, primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.
Maternity Care – First Trimester	Within seven calendar days of request.
Maternity Care – Second Trimester	Within seven calendar days of request.
Maternity Care – Third Trimester	Within three business days of request.
Maternity Care – High-risk Pregnancy	Within three business days of high-risk identification to Sentara Health Plans or a maternity provider, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery.
Behavioral Health Services (Initial and Follow-up Routine)	Must be made available as expeditiously as the member's condition requires and within no more than five 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 five business days from Sentara Health Plans' determination that coverage criteria are met.

Appointment Access Standards–Commercial

Service	Sentara Health Plans Medicaid Standard
Emergency appointments, including Crisis Services	Must be made available immediately upon the member's request
Urgent Appointments	Must be made within 24 hours of the member's request
Routine Primary Care	Must be made within 14 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations; for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently; or for routine specialty services like dermatology, allergy care, etc.
Maternity Care – First Trimester	Must be made within seven calendar days of request
Maternity Care – Second Trimester	Must be made within seven calendar days of request
Maternity Care – Third Trimester	Must be made within seven calendar days of request
Maternity Care – High-risk Pregnancy	Must be made within three days of high-risk identification or immediately if an emergency exists
Postpartum	Within 60 days of delivery
Preventive Care	Within 60 days of member's request
Routine Behavioral Health/ Substance Use Disorder Initial Visit	Within 10 business days
Routine Behavioral Health/ Substance Use Disorder Follow-up Visit	Within 14 calendar days
After-hours Care	As a condition of participation, providers must provide covered services to members on a 24-hour per day, 7-day per week basis.

Appointment Access Standards–Medicare

Service	Sentara Health Plans Medicare Standards
Urgently needed services or emergency	Must be made immediately
Services that are not emergency or urgently needed, but the member requires medical attention	Must be made within seven business days
Routine and preventive care	Must be made within 30 business days

Managing Care Gaps

To ensure optimal, timely service for our members and close gaps in patient care, we encourage following the protocol below:

- Use appropriate documentation and correct coding.
- Maintain appointment availability for patients with recent emergency department visits.
- Explain the importance of follow-up appointments to your patients.
- Contact patients who do not keep initial appointments and reschedule them as soon as possible.
- Encourage follow-up visits via telehealth when appropriate to the principal diagnosis.
- Submit claims and encounter data promptly.

Note: Learn more in the **Close Care Gaps** section of our provider website.

Provider Training Requirements and Recommendations

Required Annually

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

Encouraged

- Fraud, Waste, and Abuse
- Cultural Competency
- Trauma-informed Care `
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Resources for EPSDT Providers

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program ensures pediatric patients receive regular screenings to avoid delays in diagnosis and treatment. By visiting the Department of Medical Assistance Services (DMAS) website, providers can access educational materials, schedules, approved screening tools, and other resources needed to provide the best care for patients.

Sentara Health Plans' EPSDT Provider Guide is also available online for review or printing at **sentarahealthplans.com/providers/provider-support** in the provider education section.

Model of Care

Sentara Health Plans is uniquely positioned to provide care to the Managed Long-term Services and Support Program (MLTSS) dual-eligible population given our long-term experience with Medicaid; the Aged, Blind, and Disabled (ABD) population; and Elderly or Disabled With Consumer Direction (EDCD) participants through the Medallion 4.0 and 3.0 programs and Medicare Advantage. We have been successfully administering a Medicaid health plan in the Commonwealth of Virginia since 1996 and our current Medicare Advantage plan since 2014.

Providers are required to review the **Model of Care Provider Guide** (MCPG) within 30 days of their initial orientation date as a newly contracted provider and by January 31 each subsequent year. Training curricula are designed to ensure effective and efficient delivery of quality care to Sentara Health Plans members as well as adherence to federal and state regulations.

Fraud, Waste, and Abuse (FWA)

Detecting FWA

Sentara Health Plans is responsible for detecting and preventing fraud, waste, and abuse in accordance with the Deficit Reduction Act and the False Claims Act.

Sentara Health Plans will conduct investigations of suspected fraud, waste, and abuse of its personnel, participating providers, subcontractors, and enrollees. There is no financial threshold for case notifications. Reportable fraud, waste, or abuses may include:

- emerging fraud schemes
- suspected internal fraud or abuse by employee(s), contractor(s), or subcontractor(s)
- suspected fraud by providers who supply goods or services to Sentara Health Plans members
- suspected fraud by Sentara Health Plans members

Reporting Abuse

- Hotline: **1-866-826-5277**
- Email: **compliancealert@sentara.com**
- U.S. Mail:
  Sentara Health Plans C/O Special Investigations
  PO Box 66189
  Virginia Beach, VA 23466
- Refer to **provider manual** for more detail on this subject.

Accurate Coding and Billing

When you submit a claim for services performed for a patient, you are filing a bill and certifying that you earned the payment requested and complied with the billing requirements. If you knew or should have known a submitted claim was false, then the attempt to collect payment is illegal. Examples of improper claims include billing for services:

- you did not actually render or were not medically necessary
- performed by an improperly-supervised or unqualified employee
- performed by an employee who has been excluded from participation in federal healthcare programs
- of such low quality that they are virtually worthless
- separately that were already included in a global fee, such as billing for an evaluation and management service the day after surgery (does not apply to appropriately bundled services)

Member Identification

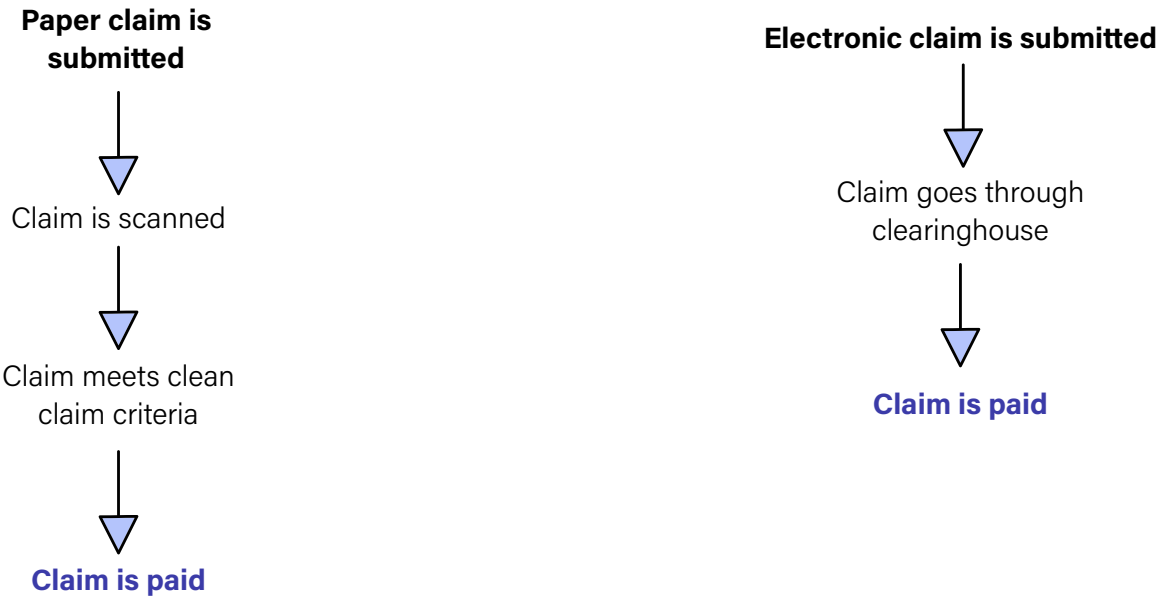
Billing and Claims

By entering into a provider agreement, you have agreed to accept payment directly from Sentara Health Plans. This constitutes payment in full for the covered services you render to members, except for copayments, coinsurance, deductibles, and any other monies listed in the "Patient Responsibility" portion of the remittance advice. You may not bill members for covered services rendered or balance bill members for the difference between your actual charge and the contracted amount. In cases where the copayment is greater than the allowed amount for services rendered, only the allowed amount for the services should be collected. Should you collect more than the allowed amount, you will be expected to refund the member the difference between the two amounts.

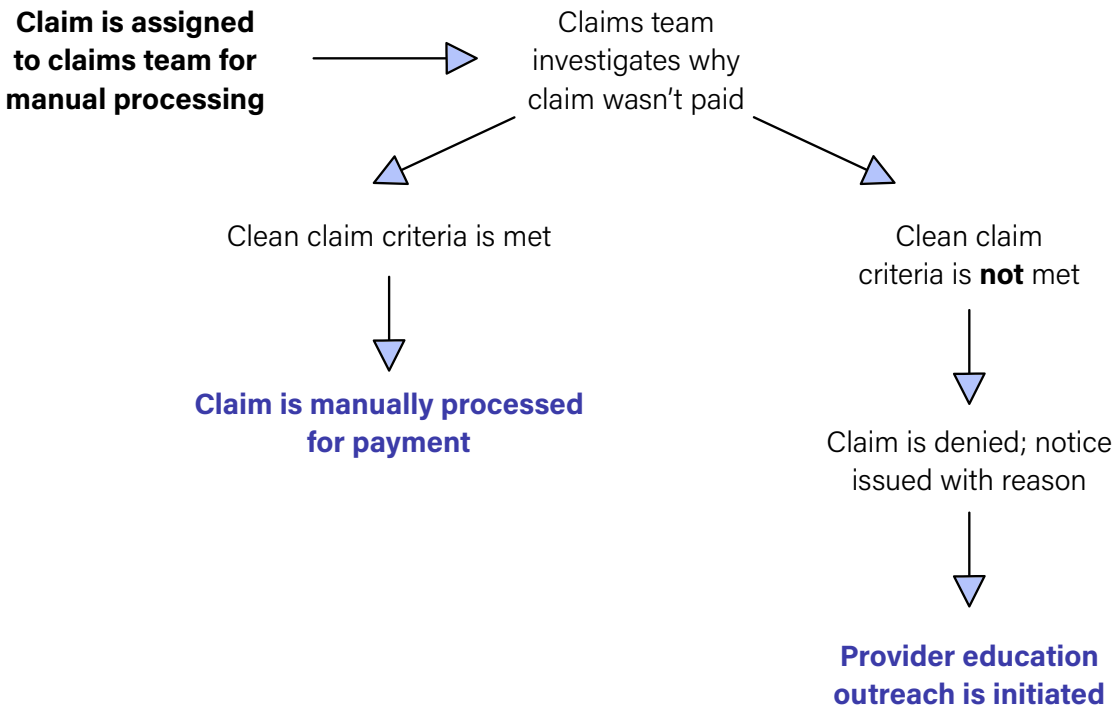
Critical Elements of Compensation and Billing:

1. **Rates and Compensation:** Provider will collect payments for covered services.
2. **Provisions:** Provider will not limit the provision of covered services to a member because of or based on any compensation arrangement between Sentara Health Plans, Inc. and provider.
3. **Billing:** Provider will bill for covered services according to billing and claims submission policies as outlined in the provider manual.
4. **Filing:** Provider will file in a timely manner—no more than 365 days after a service is rendered.
5. **Claims:** Provider shall make its best efforts to file clean claims.
6. **Payment Denial:** Claims received by Sentara Health Plans, Inc. after the 365-day period may be denied for payment. Provider shall not seek any payment from members for claims denied by Sentara Health Plans, Inc.
7. **NPI Number:** Provider must submit claims to Sentara Health Plans that include individual and group practice National Provider Identifier (NPI) numbers and taxonomy codes. Claims received without an NPI number will be rejected or denied.
8. **Taxonomy Code:** Providers will submit the correct taxonomy code, which is required for billing. Claims received without the taxonomy code will be rejected or denied.
9. **Referrals:** Provider will submit a referral form to the health plan prior to providing services for a member.

Clean Claim/Auto Adjudication Diagram



Clean Claim Criteria Not Met Diagram



Common Reasons for Denial of Payment

- errors in member name – hyphenated last names must be submitted correctly
- incorrect birthday submitted – claims must match the birth date associated with the member ID number

To learn more, review the Claims section of the **provider manual** or download the Avoiding Common Claim Submission Errors job aid from the online Provider Toolkit.

Completing Paper Claims

Sentara Health Plans requires the 02-12 version of the CMS-1500 claim form. For guidance on filling out a paper form, we align to **NUCC** guidelines.

- To expedite payment and avoid the resubmission of claims, fill out the CMS-1500 claim form as thoroughly and accurately as possible.
- Submit claims containing all data elements and industry-standard coding conventions.

Paper claims must be mailed to:

Medical Claims
PO Box 8203
Kingston, NY 12402-8203

Behavioral Health Claims
PO Box 8204
Kingston, NY 12402-8204

Filing Claims Electronically

Sentara Health Plans' preferred method of billing and payment is electronic. Electronic funds transfer (EFT) is safe, secure, and efficient, as well as less expensive than paper check payments. Clean claims are processed and paid by Sentara Health Plans within an average of seven days when submitted electronically and when payment is made through EFT. Funds are typically deposited 24 hours after payments are processed. Providers are encouraged to enroll for EFT by completing the **Electronic Payment/Remittance Authorization Agreement** on the provider web portal.

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

- We accept claims through any clearinghouse that can connect through Availity, Veradigm (Payerpath/Allscripts), or Change Healthcare.
- The Sentara Health Plans Payor ID number is **54154**.
- Providers who can receive data files in the HIPAA compliant ANSI 835 format may elect to receive EFT/ERA directly from Sentara Health Plans. The 835 transaction contains the remittance information as well as the Electronic Funds Transfer. Inquiries about direct claims submission or EFT/ERA transactions may be submitted by email to **EFT_ERA_Inquiry@sentara.com**.

Remittance Advice

Remittances are offered through Zelis Payments Network

Provider payment processing transitioned to the Zelis Payments Network. If you have already enrolled in the Zelis Payments Network, no further action is needed to continue receiving electronic payments.

New Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Setup

If not enrolled in the Zelis Payments Network, an enrollment option must be completed to continue receiving electronic payments, or payment will be issued by check and sent via U.S. mail. Alternative payment options are also available, including the Automated Clearing House Network (ACH)or virtual credit card. 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/**.

If you do not want your Sentara Health Plans payments to flow through your current Zelis Payments Network solution, other options are available. You may enroll in the Sentara Health Plans ePayment center for basic electronic funds transfer (EFT) and electronic remittance advice (ERA) services at no cost.

To enroll or for questions, call Zelis' Sentara Health Plans ePayment center membership services at **1-855-774-4392**, Monday through Thursday between 9 a.m.and 7 p.m. or Friday between 9 a.m.and 5:30 p.m. You may also email **help@epayment.center**.

Providers who are currently enrolled with Zelis Payments Network should work directly with Zelis Payments Network to ensure ERAs are routed correctly to avoid payment delays.

EFT Payment Schedule

The following information summarizes Sentara Health Plans' general payment schedule. In situations where our offices are closed, such as holidays or extremely severe weather, the scheduled payments will be processed on the next business day. While we cannot foresee every circumstance, our professionally trained staff will make every effort to adhere to the following payment schedule:

Weekly payment processing schedule:

- **Monday** - All commercial (fully insured), Medicare and Medicaid
- **Tuesday** - Sentara behavioral health and self-funded employer groups (refer to note 1)
- **Wednesday** - Federal employee groups and self-funded employer groups (refer to note 1)

Payments processed monthly:

- Provider capitation and practice management payments are processed on or before the 15th of every month.
- All remaining payment types not already listed will be processed on or before the 20th of each month.
- For providers who choose to receive their payments electronically, funds are normally deposited 24 hours after the payments are processed. Associated electronic remittance advice is usually transmitted 24 - 48 hours after payments are processed. All other providers will receive paper checks/remittances through the US postal system (refer to note 2).

Note 1: *While claims payments are processed on these days, funds are not released until the payments are funded by their associated employer group. This applies to self-funded employer groups only.*

Note 2: *While Sentara Health Plans will make every effort to adhere to the payment schedule, the availability of funds is also dependent on the provider's banking institution*

Visit our **website** for more information.

Reconsiderations and Appeals—MCO and FFS

For services rendered, providers have the right to appeal adverse actions after exhausting the Sentara Health Plans reconsideration process. Providers cannot appeal Sentara Health Plans' enrollment or termination decisions to the DMAS Appeals Division.

Appeal Process

Sentara Health Plans accepts appeals submitted in writing within 365 days from the date of service for claims appeals. Clinical appeals must be submitted within 60 days of notice of denial, unless otherwise determined by their contract with the health plan. Detailed information and supporting written documentation should accompany the appeal. A decision will be rendered within 30 business days of receipt of the appeal request, with a 14-day extension if it is in the best interest of the member.

Mail to:

Medicaid/Medicare

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

Medicaid Provider Services: **1-800-229-8822**
Medicaid Appeals and Grievances
Phone: **1-844-434-2916**
Medicaid Fax: **1-866-472-3920**

Medicare Provider Services: **1-800-927-6048**
Medicare Appeals and Grievances
Phone: **1-855-813-0349**
Medicare Fax: **1-800-289-4970**

Commercial

Sentara Health Plans Appeals and Grievances
PO Box 66189
Virginia Beach, VA 23466

Phone: **1-833-702-0037**
Commercial Fax: **1-877-240-4214**

Refund Process

When sending a refund, please send a copy of the remit, an outline of the reason the claim was paid in error, and a check to:

Sentara Health Plans Recovery Unit
PO Box 61732
Virginia Beach, VA 23466

Obtaining an Authorization

The preferred method to obtain an authorization is through the secure provider portal.

Receiving authorization is contingent upon medical necessity, as supported by medical criteria and standards of care. Sentara Health Plans does not provide incentives to influence authorization decisions, promote denials of coverage of care, nor encourage the underutilization of services. Sentara Health Plans follows the National Committee for Quality Assurance guidelines for the timeliness of utilization-management decisions.

Elective Admissions

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

The requesting provider should receive an authorization for services within fourteen (14) days if all the necessary clinical information was provided with the initial authorization request, and the service is covered under the member's benefit plan. Lack of clinical information to support authorization approval will delay processing.

Failure To Obtain Authorization

Failure to obtain authorization for services will result in the denial of payment, and the provider may be held responsible for the cost of services rendered. Authorization determines medical necessity. It does not determine the level of payment or coverage and therefore does not guarantee payment. Payment decisions are also based on the eligibility for services on the procedure date and benefits provided through the member's health plan. Please see the Sentara Health Plans Provider Manual for the list of services requiring authorization—except in the case of emergency treatment.

Urgent Authorization Requests

Authorization may also be obtained by phone for medically urgent requests. Clinical Care Services personnel are available to process faxed requests and medically urgent telephone requests Monday through Friday, 8 a.m. to 5 p.m., EST. A confidential voicemail is available between the hours of 5 p.m. and 8 a.m., Monday through Friday, and 24 hours a day on weekends and holidays. Please note on the authorization form if the request is urgent and requires expedited review. **When submitting a request for urgent authorization, note that in order to qualify, failure to receive an immediate authorization would result in the loss of life or limb or result in permanent injury.**

Vendor-facilitated Services

- **American Specialty Health Network (ASHN)**: chiropractor network claims are paid through ASHN; commercial and Medicare only; **1-800-848-3555**
- **DentaQuest:** only the FIDE-SNP (H4499-001) members; **1-888-650-1274**
- **Delta Dental:** dental network for all other plans. **1-800-927-6048**.
- **Modivcare:** transportation vendor for Medicare, Medicaid, and commercial
- **MDLive**: virtual visits; commercial, Medicare, and Medicaid
- **Nations Hearing:** discounted services for Medicare and Medicaid
- **Vision Services Plan (VSP):** routine vision care; only commercial, Medicare, and Medicaid
- **Community Eye Care (CEC):** a subsidiary of VSP will service all Medicare
- **Quest Diagnostics:** commercial, Medicare, and Medicaid

Record Documentation Standards

You must maintain accurate and complete medical records and documentation of the services you provide and ensure they support submitted claims for payment.

Good documentation ensures your patients receive appropriate care from you and other providers who may rely on your records for patients' medical histories.

> "If the service was not documented, it was not done."

Medical Records

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

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

Behavioral Health Records

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

- history of present illness
- psychiatric history
- substance use assessment
- mental status examination
- diagnosis (all five axes)
- medical history, including allergies and adverse reactions (physicians only)
- medication management (physicians only)
- allergies and adverse reactions to medications
- treatment planning
- risk assessment
- evidence of continuity of care
    - documentation of collaboration with the member's primary care provider (PCP) in medication and treatment rendered or documentation of the member's refusal to consent to same.

After obtaining the patient's informed consent prior to the release of information, the provider is expected to notify the PCP when the member presents for an initial behavioral health evaluation and continued treatment, including significant changes in the patient's condition, changes in medication, and termination of treatment.

Confidentiality of clinical information relevant to the patient under review should be contained in the record or in a secure computer system, stored and accessible in a nonpublic area, and available upon identification by an approved person. All office staff must comply with the HIPAA Privacy and Security Rules.

Patient information should be in chronological or reverse chronological order and in a consistent, logical format.

Reporting Critical Incidents

Reporting critical incidents:

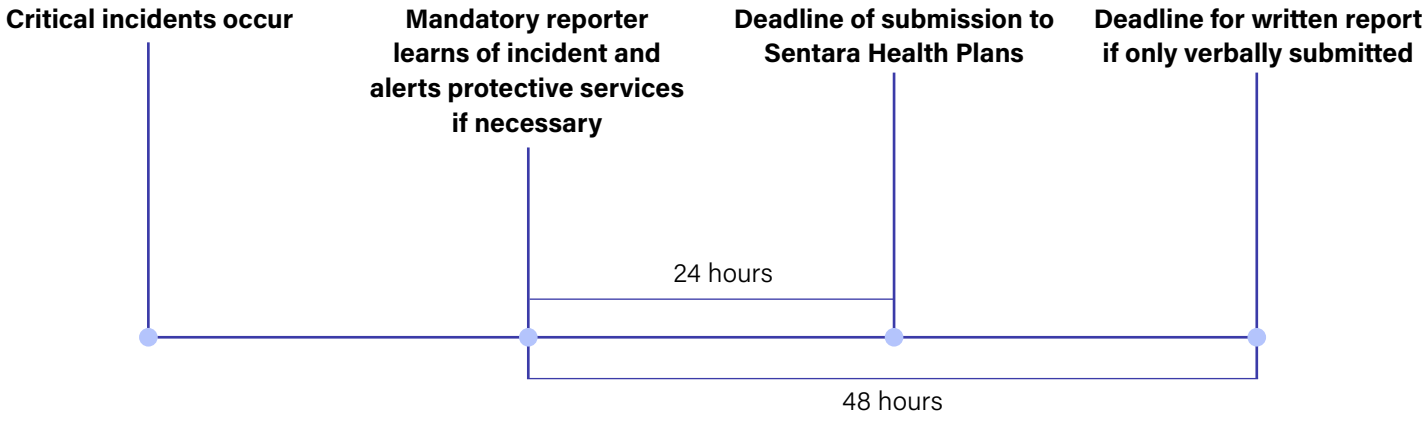
- ensures member/patient safety
- avoids repeatable errors
- addresses areas of concern
- complies with regulatory reporting requirements

Providers are required to provide Sentara Health Plans with the following information for any suspected abuse, neglect, or exploitation reported to Adult or Child Protective Services (APS or CPS):

- member name, address, and telephone number
- date of birth or age, sex, and race
- member ID or Medicaid ID
- provider name, NPI, and contact number
- nature of incident
- contact person
- name of agency notified and reference number
- date and time reported
- names and ages of other persons living with the member, including relationship
- name, address, and telephone number of suspected abuser(s), including relationship to member

Reporting Timeline Diagram

- Immediately report to appropriate protective services agency.
- Within 24 hours of knowledge of the incident, it must be reported to Sentara Health Plans.
- Within 48 hours of knowledge of the incident, you must provide written documentation. If you are reporting an incident by phone, you must report within 24 hours of knowledge.



Resources

To learn more about critical incident reporting, you may review the educational resources located on our **website.**

Definitions

1. **Billed Charge:** the actual amount charged by provider for any covered service furnished to a member.

2. **Clean claim:** a claim that does all of the following:

   a. Identifies the provider that provided the service with industry-standard identification criteria, including billing and rendering provider names, identification numbers, and addresses;

   b. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient was an enrollee at the time of service;

   c. Identifies the service rendered using an industry-standard system of procedure or service coding, or, if applicable, a methodology required under the provider contract. The claim shall include a complete listing of all relevant diagnoses, procedures, and service codes, as well as any applicable modifiers;

   d. Specifies the date and place of service;

   e. If prior authorization is required for the services listed in the claim, contains verification that prior authorization was obtained in accordance with the provider contract for those services; and

   f. Includes additional documentation specific to the services rendered as required by the carrier in its provider contract. Notwithstanding the above criteria, a claim shall be considered a clean claim if a carrier has failed timely to notify the person submitting the claim of any defect or impropriety in accordance with this section.

3. **Covered Services:** those services, drugs, supplies, and equipment for which coverage benefits are available under the healthcare plans. Covered services beneficiaries are given benefits according to the terms and conditions of the health plan.

4. **Copayment:** charges for covered services collected directly by provider from member as payment, in addition to the fees paid to provider by the health plan.

5. **Deductible:** a dollar amount which a member is responsible to pay before the covered service.

6. **Electronic Health Record (EHR):** an electronic record of clinical services rendered by a participating provider to a member.

7. **Fee Schedule:** a list of the maximum amounts allowed per unit for covered services.

8. **Medically Necessary:** those covered services as provided by a participating provider which are:
   - required to identify, evaluate, or treat the member's condition, disease, ailment, or injury—including pregnancy-related conditions
   - in accordance with recognized standards of care for the member's condition, disease, ailment, or injury
   - appropriate regarding standards of good medical practice
   - not solely for the convenience of the member or a participating provider
   - the most appropriate supply or level of service which can be safely provided to the member

9. **Noncovered Services:** those healthcare services that are not covered services.

10. **Provider Network:** a group of participating providers that, through a contractual relationship, supports some or all products in which members are enrolled.

11. **Quality Improvement:** the processes established and operated by the health plan, or its designee, to evaluate and promote the quality and cost-effective delivery of covered services.

12. **Clean/Complete Application:** provider meets eligibility criteria for Sentara Health Plans credentialing, and application submission includes all provider information and documentation required for Sentara Health Plans to proceed with the credentialing process. Clean/complete status is determined by the Sentara Health Plans Credentialing Department upon initial application review.

13. **Taxonomy:** a unique 10-character code that designates a healthcare provider's classification and specialization.

Helpful Resources

The resources below, and more, can be found at sentarahealthplans.com/providers/provider-support:

Sentara Health Plans Commercial and Medicare Provider Manual

DMAS Provider Manuals

EPSDT Supplement B

MES Provider Portal

Sentara Health Plans Quick Reference Resources:

- Clinical references
- Authorizations

E-booklets:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provider Guide
- Model of Care