Commercial and Medicare 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 Provider Manual was last updated on February 17, 2025. Updates to the provider manual may occur due to the introduction of new programs, changes in contractual and regulatory obligations, and updates to existing policies. The most current information is available on the **Sentara Health Plans Provider Website**.

Sentara® Health Plans

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Sentara Health Plans Key Contacts

Sentara Health Plans provides convenient, self-service tools to the providers through the provider portals. To register for Availity or access the legacy Sentara Health Plans portals, click **here**.

Provider and Member Services

- Provider Services
  Phone: **1-800-229-8822**
  Fax: **757-552-7316**
- Behavioral Health Provider Services
  Phone: **1-800-648-8420**
  Fax: **757-552-7499**
- Member Services
  Phone: **1-800-881-2166**

Clinical Care Services

- Medical Authorizations and Medical Benefit Drugs for Commercial Members
  Phone: **1-800-229-5522**
- Medical Authorizations and Medical Benefit Drugs for Sentara Health Plans Medicare and Medicaid Products
  Phone: **1-888-946-1167**
- Authorizations Behavioral Health Providers
  Phone: **1-800-229-8822**
- Nurse Advice Line
  Phone: **1-800-394-2237**
- Behavioral Health Crisis Line
  For a psychological medical emergency, please call **9-8-8**, the National Crisis Hotline, or go to the nearest emergency room.
- Sentara Health Plans Case Management Services (Direct)
  Phone: **1-866-503-2730**
- Case Management Partners in Pregnancy
  Phone: **1-866-239-0618**
- Quality Improvement
  Phone: **1-844-620-1015**
  Fax: **1-844-518-0706**

Pharmacy Services

- Specialty Pharmacy (Proprium Pharmacy)
  Phone: **1-855-553-3568**
  Web: **propriumpharmacy.com/for-prescribers/**
- Exchange Pharmacy Provider Services
  Phone: **1-800-229-5522**
- Commercial Pharmacy Provider Services
  Phone: **1-800-229-8822**
- Mail Order Pharmacy (Express Scripts)
  Phone: **1-877-728-0179**
- Medicare Pharmacy Provider Services
  Phone: **1-888-946-1167**

Critical Incidents

- Email: **CIReporting@sentara.com**
  Toll-Free Phone: **1-844-620-1015**
  Local Phone: **757-252-8400**
  Toll-Free Fax Line: **1-833-229-8932**

Telephone for the Deaf and Disabled (TDD)

- Phone (Virginia Relay): **711**

Health and Preventive Services

- Phone: **1-833-477-5464**
  Email: **wellness@sentara.com**

Fraud and Abuse

- Hotline: **1-866-826-5277**
  Email: **compliancealert@sentara.com**
- U.S. Mail: Sentara Health Plans
  Program Integrity Department
  1300 Sentara Park
  Virginia Beach, VA 23464

Sentara Health Plans Key Contacts

Network Management

- To contact your assigned network educator, please email **contactmyrep@sentara.com**.

Medical Authorizations

- Follow the directions on the adverse determination letter.
- Mail: Clinical Care Services
  PO Box 66189
  Virginia Beach, VA 23466
- Urgent Fax: **1-888-576-9675**

Claim Payment Reconsiderations

- Mail: Medical Claims
  PO Box 8203
  Kingston, NY 12402-8203
- Mail: Behavioral Health Claims
  PO Box 8204
  Kingston, NY 12402-8204
- Overpayments
  Phone: **1-800-229-8822**
  Mail: Sentara Health Plans Provider Receivables
  PO Box 66189
  Virginia Beach, VA 23466

Appeals and Complaints – Commercial

- Commercial Member Services Phone:
  1-800-543-3359
  Fax: **1-877-240-4214**
- Mail: Sentara Health Plan
  Appeals and Grievances
  PO Box 66189
  Virginia Beach, VA 23466
- Commercial Appeals Email:
  commappeals@sentara.com
- Commercial Complaints Email:
  commcomplaints@sentara.com

Appeals and Grievances – Medicare

- Medicare Member Services Phone: **1-800-927-6048**
  Fax: **1-800-289-4970**
- Mail: Sentara Health Plans
  Medicare Appeals
  PO Box 62876
  Virginia Beach, VA 23466
- In-Person Delivery:
  1300 Sentara Park, Virginia Beach, VA 23464
- Medicare Appeals Email:
  MedicareAppeals@sentara.com
- Medicare Grievance
  Email: **Medicare_Griev@sentara.com**

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Introduction

As a participating provider, you are an integral member of our team. We thank you for partnering with Sentara Health Plans to promote the maintenance of health and the management of illness and disease by providing access to quality healthcare and the best in customer service to the communities we serve.

Sentara Health Plans Resources for Providers

Sentara Health Plans provides several resources for providers to obtain information regarding membership, products, policies, and procedures:

Provider Manual

This provider manual identifies contacts and resources within Sentara Health Plans and provides basic information for member identification, credentialing procedures, requirements for prior authorization, and claim and reimbursement procedures. The provider manual also offers directions to locate detailed lists, contact information, and policies on the provider website. The provider manual consists of a core document that includes general policies and procedures for all plan types and specific information for Sentara Health Plans Medicare and Commercial plans. Here are two provider manual supplements containing information specific to providers participating in the Medicare Advantage HMO and providers participating in Sentara Community Complete, the Dual-eligible Special Needs Plan (D-SNP).

Providers should refer to the Sentara Health Plans Medicaid program Provider Manual for Medicaid program specific information.

The provider manual was developed to assist providers in understanding the administrative requirements associated with managing a member's healthcare. This provider manual, including all sources that are referenced by and incorporated herein via web-link or otherwise, is a binding extension of your provider agreement and is amended as our operational policies or as regulatory requirements change. Many of the policies and procedures that are referenced by or incorporated into this provider manual are available on the provider website.

Should the terms of the body of the provider agreement or its exhibits (excluding the provider manual exhibit) conflict with this provider manual, then the body of the provider agreement and its exhibits (excluding the provider manual exhibit) controls.

In addition to the provider manual being available online, it is also available in paper form by written request. Providers are responsible for complying with updates to the provider manual, as they are made available from time to time. Sentara Health Plans notifies providers of updates to this manual via email and website notification 60 days in advance of operational changes that could impact providers doing business with Sentara Health Plans.

Online

Up-to-date contacts, policies and procedures, forms, and reference documents are available to providers through the **provider website**.

Provider Portal

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

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

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

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

Provider Training

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

Providers are encouraged to take Fraud, Waste, and Abuse; Trauma Informed Care; and Cultural Competency training during onboarding and as ongoing training.

Quarterly Webinars

Online educational webinars are held quarterly and are used to provide Sentara Health Plans updates, provide refreshers on how to successfully do business with Sentara Health Plans, and allow providers to ask questions. Providers must register on the Sentara Health Plans provider website by the day before each event. The schedule is listed on the **Provider Webinars** page and in the provider newsletter, along with other educational opportunities.

Mailings and Newsletters

Providers may be notified of updates or changes to policies via targeted mailings or email. We notify providers of news, updates, or changes to our policies via our quarterly provider newsletter, with an email notification when the newsletter is available on the provider website.

Telephone

Medical and behavioral health providers may contact provider services by phone. In the event an issue cannot be satisfactorily resolved by provider services, providers should contact their assigned network educator.

A complete directory of phone and fax numbers for Sentara Health Plans departments (including contacts for after-hours) may be found online on the provider website under "Contact Us." A listing is also provided in the "Sentara Health Plans Key Contacts" section at the top of this manual.

Managing Provider Contact Information

Notice of changes, amendments, and updates to this provider manual and any sources that are referenced by and incorporated herein are communicated to you via the Sentara Health Plans website and by email (for providers that have notified Sentara Health Plans of their email address) sixty (60) days before the changes become effective. For this reason, it is critical that you keep your email address current so that you can receive electronic communications with new and updated operational information, including amendments to your provider agreement and the provider manual. It is your responsibility to ensure that the email address that you have provided to us is correct and current. To update your email address and directory information, contact your network educator or email **contactmyrep@sentara.com**.

HIPAA Privacy Statement

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

Sentara Health Plans maintains compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 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.

Product Overview

Sentara Health Plans offers several health plans designed to meet the needs of most large and small employer groups as well as individuals and families. In addition, Sentara Health Plans offers plans for Medicare Advantage and managed Medicaid, including plans for dual-eligible members. Product offerings and designs are subject to change and often vary by geographic area. Sentara Health Plans is the trade name for Sentara Health Plans issuing HMO and POS plans, Sentara Health Insurance Company issuing PPO plans, and Sentara Health Administration Inc., providing administrative services for self-funded employer group health plans.

Plans Sold on the Health Insurance Marketplace

Sentara Health Plans is a health insurance issuer that is authorized by the U.S. Department of Health and Human Services and the Virginia State Corporation Commission, Bureau of Insurance to sell qualified health plans (QHPs) to members in Virginia's Health Benefit Exchange (HBE or "Marketplace").

Product Funding Types

When the bottom of the member ID card shows "Administered by Sentara Health Administration, Inc." on the front or back of the card, it is an indicator that the plan is self-funded. These plans may also have employer-specific logos as well as the Sentara Health Plans name. Because medical costs are funded directly by the employer, employer-directed exceptions are common to these plans. Please check benefits on the Availity provider portal or call Sentara Health Plans provider services to obtain plan specifics.

Commercial Product Information

The following tables show general information for commercial plan types currently offered by Sentara Health Plans. For plans with a deductible, the annual deductible does not apply to preventive care. Plan type offerings may vary by geographic location. Specific benefit information is available via the Availity provider portal or by calling provider services.

HMO PLAN TYPES
Underwritten by Sentara Health Plans

All HMO Plan Types:

- No referrals required
- Primary care provider (PCP) selection required
- No out-of-network coverage except emergency care
- Some services require prior authorization

Product Name	Description	Features
Sentara Vantage	HMO-type plan	• Includes copayments with some services requiring coinsurance • May have deductibles

HMO PLAN TYPES Underwritten by Sentara Health Plans		
Sentara Vantage Equity/ Sentara Vantage HSA	• High Deductible Health Plan (HDHP) • Includes a Health Savings Account (HSA) (I) with most plans • HSAs administered by HealthEquity • HSAs funded and owned by the employee to help pay patient out-of-pocket expenses • Debit card or remit may indicate HealthEquity	• Includes copayments • May have coinsurance • Annual deductible
Sentara Vantage Design/Sentara Vantage HRA	• HDHP • A Health Reimbursement Account (HRA) funded by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses	• Includes coinsurance • Some services may require copayments • Annual deductible

PPO PLAN TYPES
Underwritten by Sentara Health Insurance Company

All PPO Plan Types:

- In-network and out-of-network coverage
- Primary care provider (PCP) selection is encouraged but not required
- No referrals required
- Some services require prior authorization

Product Name	Description	Features
Sentara Plus	Standard PPO	• Includes copayments with some services requiring coinsurance • May have deductible
Sentara Plus Design/ Sentara Plus HRA	• High Deductible Health Plan (HDHP) • A Health Reimbursement Account (HRA) funded and owned by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses	• Includes coinsurance • Some services may require copayments • Annual deductible
Sentara Plus Equity/ Sentara Plus	• HDHP • A Health Savings Account (I) with most accounts administered by HealthEquity • Accounts funded and owned by the employee to help pay patient • out-of-pocket expenses • Debit card or I remit may indicate HealthEquity	• Includes copayments • May have coinsurance • Annual deductible

POS (Point of Service) PLAN TYPES Underwritten by Sentara Health Plans		
All POS Plan Types: • No referrals required • Primary care provider (PCP) selection required • Includes an out-of-network benefit • Some services require prior authorization		
Sentara POS	• Operates similar to HMO Plans except includes out-of-network coverage at a reduced benefit level similar to PPO • Offers high deductible options with a Health Savings Account (I) or a Health Reimbursement Account (HRA) similar to HMO plans	• Includes copayments with some services requiring coinsurance • May have deductibles
INDIVIDUAL AND FAMILY Qualified Health Plans Underwritten by Sentara Health Plans		

Sentara Individual & Family Health Plans	• Healthcare purchased directly or through the health insurance marketplace by individuals
	• Plans are HMO:
	  • Sentara Gold
	  • Sentara Silver
	  • Sentara Bronze
	• Cost Share Reduction Plans also available through the health insurance marketplace
		Refer to the information for the plan purchased.

STRUCTURED NETWORKS		
Sentara Direct Plans	A two-tiered network of doctors and providers for all employer and Individual plan area residents	Members pay a lower cost share when choosing a provider in Tier 1 for a specific set of benefits

For plan information regarding Sentara Health Plans Medicare HMO or Sentara Community Complete, please reference the appropriate provider manual or provider manual supplement.

Member Identification

Member ID Cards

Members receive identification cards for each enrolled member of the family. 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. The sample cards shown are representative of each of the Sentara Health Plans options. ID cards vary slightly due to specific differences between plans and employer groups.

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

Eligibility Verification

Since a member's eligibility status may change, member coverage should be verified at the time of service. Providers may access the Availity provider portal or call the Sentara Health Plans interactive voice response (IVR) system 24 hours a day, 7 days a week for the most current eligibility in Sentara Health Plans systems. Sentara Health Plans verifies coverage based on the most current data available from the employer/payer. Retroactive changes could alter the member's status; therefore, verification of eligibility is not a guarantee of payment.

Credentialing and Recredentialing

Join the Network

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

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

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

Credentialing Overview

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

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

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

Scope

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

Delegated Credentialing

If you are participating through an organization that has been approved and contracted to perform delegated credentialing, your credentialing process may differ somewhat from the process described in this manual. Please contact your organization for further information.

Organizational Contracting Approval

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

Marriage and Family Therapists and Mental Health Counselors

Effective January 1, 2024, the Centers for Medicare & Medicaid Services (CMS) recognizes licensed Marriage and Family Therapists (MFT) and licensed Mental Health Counselors (MHC) as a new Medicare provider type. Payment for these services under Part B of the Medicare program began on January 1, 2024. CMS defines MFT services as services furnished by an MFT for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MFT is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service. CMS defines MHC services as services furnished by a mental health counselor (MHC) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MHC is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service. For more information from CMS, please visit their website. Contact the behavioral health contract manager assigned to your practice to determine if your agreement will need to be amended.

Long-Term Services and Supports (LTSS)

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

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

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

Council for Affordable Quality Healthcare (CAQH)

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

Contact Information for CAQH

Website: **caqh.org/providers**

CAQH ProView - Sign In

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

Supporting Documents

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

- Current state medical licenses
- DEA certificate
- Current malpractice insurance face sheet indicating the amount of coverage:
  - For the Commonwealth of Virginia, providers must maintain coverage in amounts not less than the medical malpractice cap currently in effect under the Virginia Code (the "Code"). Medical Professional Liability (malpractice) insurance in the amount equal to, not less than, the limitation on recovery for certain medical malpractice actions specified in Section 8.01-581.15 of the Code of Virginia, as such Section may be hereafter amended or superseded (currently $2,650,000 per occurrence) and twice that amount (currently $5,300,000) annual aggregate. These limits change year to year, and it is advised that the provider review the Code annually, upon renewal of their policy, to ensure they have the correct limits applied to their current policy. In states other than Virginia, if the state does not have a requirement for minimum medical malpractice coverage, the provider must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year. Non-prescribing Sentara Health Plans behavioral health Virginia, individual non-physician providers must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.
- Curriculum vitae (resume) that includes work history for the past five years

Where applicable, providers should also submit:

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

Credentialing Process

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

Verifications

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

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

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

- Verification of current professional liability insurance in amounts required by contracts for the past five years for physicians; two years for ancillary providers
- Verification of all current state licensures and past state licensures

- Verification of hospital privilege status at a participating hospital, if applicable, or proof of acceptable coverage arrangements with a participating physician
- Verification of Medicaid participation in good standing, if applicable
- Verification of Medicare participation in good standing, if applicable
- Review of the OIG Sanction Report, HIPDB and **SAM.gov** for sanctions

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

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

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

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

Reimbursement for Services Rendered While Credentialing Is Pending for Commercial Plans

In accordance with § 38.2-3407.10:1 of the Code of Virginia, as applicable, Sentara Health Plans may reimburse new provider applicants 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 new provider applicant's credentialing application by Sentara Health Plans Credentialing Committee. If the new provider applicant is not approved, any claims submitted for services rendered during this period will be denied, and the provider is prohibited from collecting any amount for these services from the member.

Claims for services rendered during the pending application period should be submitted to Sentara Health Plans after the provider receives notification that the Sentara Health Plans credentialing, and provider record configuration process is complete.

To submit claims to Sentara Health Plans pursuant to § 38.2-3407.10:1 of the Code of Virginia , 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 that the health plan is in the process of determining if the provider will be credentialed or not. More information on the required member notice can be found in our Doing Business with Sentara Health Plans Provider Guide or the Sentara Health Plans Credentialing Guide.

Recredentialing

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

Confidentiality and Provider Rights

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

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

An applicant may review any documentation submitted by the applicant in support of their application, together with any information received from outside sources such as: malpractice carriers, state licensing agencies or certification boards. Practitioners may not review any peer review information obtained by Sentara Health Plans. Practitioners are informed of this Right through the Credentialing Program Description which is posted publicly on Sentara Health Plans website.

Providers may choose to request to review such information, at any time, by sending a written request, to the Credentialing Department online at **SHPCredDept@Sentara.com** or through the United States Postal Service at:

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

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

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

Ongoing Monitoring

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

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

Credentialing for Facility and Ancillary Providers

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

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

- Be conducted at least every three years
- Confirm that the provider is in good standing with state and federal regulatory bodies
- Confirm, when applicable based on provider type, that the provider has been reviewed and approved by an acceptable accrediting body
- Implement standards of participation for any provider that has not been approved by an acceptable accrediting body and the process for assuring review of CMS' site audit
- Proof of general and professional liability insurance is required in the amount (at minimum), $1 million per occurrence and $3 million per aggregate

Facilities and ancillaries must provide Sentara Health Plans with copies of current accreditation certificates (if applicable), or Medicare certification survey results and state licensures, as applicable to each contracted facility or ancillary provider.

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

Notice of Suspension Requirement

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

Accreditations and Certifications

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

Accreditation Association for Ambulatory Health Care AAAHC

Accreditation Commission for Health Care, Inc. ACHC

American Association for Accreditation of Ambulatory Surgery Facilities, Inc. AAASF

Association for the advancement of Blood & Biotherapies AABB

American Board for Certification in Orthotics and Prosthetics ABCOP

American College of Radiology ACR

American Academy of Sleep Medicine AA^{SM}

American Association for Laboratory Accreditation A2LA

American Speech-Language Hearing Association ASHA

American Society for Histocompatibility and Immunogenetics ASHI

National Children's Alliance Behavioral Health Center of Excellence BHCOE

College of American Pathologists CAP

Commission on Accreditation of Rehabilitation Facilities CARF

Commission for the Accreditation of Birth Centers CABC

Commission for the Accreditation of Birth Centers CABC

Centers for Medicare and Medicaid Services CMS

Center for Improvement in Healthcare Quality CIHQ

Council on Accreditation for Children and Family Services, Inc COA

Durable medical equipment (DME), Prosthetics, Orthotics, Supplies, Pharmacy, Homecare, etc. DMEPOS

Healthcare Facilities Accreditation Program HFAP

National Association of Speech and Hearing Center NASHC

National Urgent Care Center Accreditation NDAC

National Association of Boards of Pharmacy NABP

Community Health Accreditation Partner CHAP

The Joint Commission JCAHO

Det Norske Veritas Healthcare, Inc. (DNV) – Hospitals DNV

- Accreditation Program Name: National Integrated Accreditation for Healthcare Organizations (NIAHO) NIAHO
- Approved by CMS: 09-26-08 (per Federal Register)
  DNV Healthcare/NIAHO Board for Orthotist/ Prosthetist Certification BOC

  Continuing Care Accreditation Commission (CARF-CCAC) CCAC

Healthcare Quality Association on Accreditation HQAA

National Urgent Care Center Accreditation NUCCA

The Compliance Team TCT

The only exception made for hospital accreditation is when a facility is newly opened. If the hospital is newly opened, documentation of patient safety plans and records from a state or federal regulatory body that has reviewed the hospital must be forwarded to Sentara Health Plans. Full accreditation must be acquired within three years to continue the contract with Sentara Health Plans.

Disciplinary Action

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

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

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

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

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

Provider Directory and Data Accuracy

Provider Directory Information

Providers contact and availability information in the Sentara Health Plans online and print directories is the primary source for members to access medical care. Providers must notify Sentara Health Plans of any changes in Sentara Health Plans directory information to maintain member access. Except for emergency situations, providers must notify Sentara Health Plans in advance of closing their practice to new patients. Prior notice of termination is required in writing for member notification and in accordance with the terms of the provider agreement. Participation in CMS-mandated directory information audits performed by Sentara Health Plans is required.

Provider Access and Member Care

Provider Availability: Access and After-hours Standards

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

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

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

Sentara Health Plans Appointment Standards

Appointment access standards for commercial (HMO/POS/PPO) plans:

Service	Sentara Health Plans Commercial Standards
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 three business days of requests
Maternity care – high-risk pregnancy	Must be made within three days of high-risk identification, or immediately if an emergency exists

Service	Sentara Health Plans Commercial Standards
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 for Medicare plans:

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

Continuity and Coordination of Care

Ongoing collaboration between primary care providers (PCPs), specialists, and behavioral health providers, as well as between PCPs and other types of providers, promotes a continuous plan of care that benefits the member. Other types of providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, and mental health services (MHS) providers.

Sentara Health Plans monitors and identifies potential problems with continuity and coordination of care for all our members. Information on continuity and coordination of care is collected at the time of Health Effectiveness Data and Information Set (HEDIS) chart reviews. Sentara Health Plans also monitors continuity and coordination through transitions in care (changes in management of care between providers, changes in settings, or other changes in which different providers become active or inactive in providing ongoing care for a patient).

If a provider leaves Sentara Health Plans' network, except when terminated for cause, members will be able to continue to receive care, and the provider will provide care subject to the following during a transition period set forth below ("Transition Period"):

- For a period of at least 90 days from the date of the provider's termination.
- Through the provision of postpartum care directly related to the delivery for members who have been medically confirmed to be pregnant at the time of the provider's termination.
- For the remainder of the member's life for care directly related to the treatment of Terminal Illness. "Terminally ill" is defined under §1861 (dd) (3) (A) of the Social Security Act.
- For up to 180 days for members determined by a medical professional to have a life-threatening condition at the time of a provider's

termination for care directly related to the life-threatening condition.

- For members admitted to and receiving treatment in any inpatient facility at the time of a provider's termination, admission and treatment will continue until the enrollee is discharged from the inpatient facility.

For commercial plans only, members who are scheduled to undergo a nonelective surgery from the provider, treatment may continue for the earlier of a 90-day period beginning on the date of notice of the termination or the date until postoperative care from such provider with respect to the surgery is complete.

Cultural Competency

Delivery of culturally competent care allows healthcare providers to appropriately care for, assess, address, and respect healthcare concerns including cultural health beliefs, behaviors, values, and needs of members with diverse cultural and linguistic needs. In promoting health equity, Sentara Health Plans providers will focus on developing, strengthening, and supporting procedural and outcome fairness in systems, procedures, and resource distribution mechanisms to create equitable opportunity for all individuals including the following populations:

- Members with spoken language proficiency and with limited English (language) proficiency or reading skills
- Members who have identified their preferred spoken language for healthcare in a language other than English (e.g., American Sign Language, a specific language not provided as an option, or "Other" as a response option)
- Members who have requested their written materials in a language other than English (including Braille)
- Ethnic, cultural, racial, or religious minorities
- Members with disabilities
- Members identifying as lesbian, gay, or homosexual, straight or heterosexual, bisexual, undecided/don't know, other diverse sexual orientation, those who choose not to disclose, unknown, or the information is unavailable
- Members identifying as male, female, transgender male/trans man/female-to-male (FTM), transgender female/trans woman/male-to-female (MTF), genderqueer (neither exclusively male nor female), other diverse gender identities, those who choose not to disclose, unknown, or the information is unavailable
- Members who identify their pronouns, those who choose not to disclose, or the information is unavailable
- Members living in rural areas and other areas with high levels of deprivation
- Members who are adversely affected by persistent poverty or inequality

Providers are encouraged to:

- Build rapport by providing respectful care
- Determine and provide, if the member needs culturally and linguistically appropriate services, including but not limited to interpreter or translation services
- Remember that some cultures have specific beliefs surrounding health and wellness
- Ensure that the member understands diagnosis, procedures, and follow-up requirements
- Offer health education materials in languages that are common to your patient population and/or per member's preferred language
- Be aware of the tendency to stereotype certain cultures unknowingly
- Ensure staff receive continued education in providing culturally competent care

Providers are encouraged to complete Cultural Competency Training. Online training is available in the provider support section of the Sentara Health Plans website located **here**. Upon completion of the training, providers should complete the Cultural Competency Attestation Form found **here** or on the Provider Update Form (located under the "other" checkbox).

The Sentara Health Plans provider directory displays cultural competence as a feature on all provider profiles, informing members which providers have completed the training.

Sentara Community Complete (D-SNP)

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

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

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

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

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

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

Quality Improvement

Sentara Health Plans, through its commitment to excellence, has developed a comprehensive program directed toward improving the quality of care, safety, and appropriate utilization of services for our members. The Quality Improvement (QI) program is designed to implement, monitor, evaluate, and improve processes within the scope of our health plan on a continuous basis to improve the health of our members every day. Sentara Health Plans providers are required to comply with the QI program.

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.

HEDIS®[1]

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

[1]HEDIS® 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 their respective field
- Considerate of the needs of the members
- Reviewed and updated, at minimum, every two years, or sooner if needed
- Disseminated to practitioners and members upon adoption, revision, and request
- Used to provide a basis for utilization decisions, member education, and service coverage

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 judgment 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 the health plan's CPGs, please contact the member safety department at **757-252-8400** or toll-free at **1-844-620-1015**. CPGs are also available online via the health plan's **website**.

Sentara Health Plans' Member Safety/Quality Improvement (QI) Program

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

The goal of continuously improving the quality of care provided is to improve the overall health status of our members. The measurement of improvement of health status can be demonstrated by health outcomes. Sentara Health Plans is committed to improving the communities where our members live through participation in public health initiatives on the national, state, and local levels and the achievement of public health goals.

This continuous assessment uses quality improvement methodologies such as Six Sigma, Root Cause Analysis, and Plan, Do, Study, Act (PDSA). The QI Program is a population-based plan that acts as a road map in addressing common medical problems identified within our population. The Sentara Health Plans QI Program activities include the elements of:

- Identification of performance goals
- Internal and external benchmarks
- Data collection and establishment of baseline measurements
- Barrier analyses, trending, measuring,

and analyzing

- Development and implementation of corrective interventions, as needed

The Sentara Health Plans QI Program is designed to monitor, assess, and continuously advance care and the quality of services delivered. The scope of the QI Program is integrated within clinical and nonclinical services provided for Sentara Health Plans' members. The program is designed to monitor, evaluate, and continuously improve the care and services delivered by contracted practitioners and affiliated providers across the full spectrum of services and sites of care. The program encompasses services rendered in ambulatory, inpatient, and transitional settings and is designed to resolve identified areas of concern on an individual and system-wide basis.

The QI Program will reflect the population served in terms of age groups, disease categories, special risk statuses, and diversity. The QI Program includes monitoring of community-focused programs, practitioner availability and accessibility, coordination and continuity of care, and other programs or standards impacting health outcomes and quality of life.

The scope of the QI Program includes oversight of all aspects of clinical and administrative services provided to our members, to include:

- Program design and structure
- Quality Improvement activities that comply with CMS, NCQA, DMAS, and other regulatory entities
- Care management (to include complex case management, behavioral health, care transitions and end of life planning) and chronic care management programs that are member-centric and address the healthcare needs of members with complex medical, physical, and mental health conditions, assessments of drug utilization for appropriateness and cost-effectiveness
- Utilization management focused 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 recredentialing of physicians, practitioners, and facilities
- Compliance with NCQA accreditation standards
- Audits and evaluations of clinical services and processes
- Development and implementation of clinical standards and guidelines
- Measuring effectiveness
- Evidenced-based care delivery
- Potential quality of care and safety concerns

Each year, Sentara Health Plans develops a Member Safety Quality Program Description, Annual Evaluation, and Work Plan that outlines efforts to improve clinical care and service to members. Providers may request a copy of the current Quality Program Description and Annual Evaluation by calling the network management department. Information related to QI initiatives is also available on the provider website and in provider newsletters.

The Sentara Health Plans Quality Program Description, Annual Evaluation, and Work Plan is a comprehensive document or a set of documents that serves our culturally diverse membership. It describes, in plain language, the QI program's governance, scope, goals, measurable objectives, structure, responsibilities, annual work plan, and annual evaluation.

The primary objective of Sentara Health Plan's QI Program is to continuously improve the quality of care provided to members to enhance the overall health status of the members. Improvement in health status is measured through HEDIS information, internal quality studies, and health outcomes data with defined areas of focus. Sentara Health Plans has defined objectives to support each goal in the pursuit of improved outcomes.

The following are identified functions of the QI Program:

- Provide the organization with an annual Quality Program Description, Quality Annual Evaluation, and Quality Work Plan
- Coordinate the collection, analysis, and reporting

of data used in monitoring and evaluating care and service, including quality, utilization, member service, credentialing, and other related functions managed at the plan level or delegated to vendor organizations

- Identify and develop opportunities and interventions to improve care and services
- Identify and address instances of substandard care, including member safety
- Monitor, track, and trend the implementation and outcomes of quality interventions
- Evaluate effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards
- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into the primary care practices
- Promote collaboration between the QI and Population Health Programs
- Report relationships of QI department staff and the QI Committee and sub-committee structure
- Provide resource and analytical support
- Delegate QI activities, as applicable
- Collaborate interdepartmentally for QI-related activities
- Outline efforts to monitor and improve behavioral healthcare and the role of designated behavioral healthcare practitioners in the QI Program
- Define the role of the designated physician within the QI Program, which includes participating in or advising the QI Committee or a subcommittee that reports to the QI Committee
- Define the role, function, and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities (e.g., clinical subcommittees, ad hoc task forces, or multidisciplinary work groups or subcommittees)
- Describe practitioner participation in QI Committee and how participating practitioners are representative of the specialties in the organization's network, including those involved in QI subcommittees outline the organization's approach to address the cultural and linguistic needs of its membership
- Provide guidance on how to report member critical incidents (inclusive of quality of care, quality of service, and sentinel events)
- Provide training materials for providers and organization employees on cultural competency, bias, and/or diversity and inclusion
- Utilize performance measure data for continuous quality improvement (CQI) activities

Goals of Quality Improvement Program

One of the primary goals of the Sentara Health Plans Quality Improvement Program is to achieve a five-star rating from NCQA by ensuring the delivery of high-quality culturally competent healthcare, particularly to members with identified healthcare disparities. The organization's healthcare modalities will emphasize medical, behavioral health, and pharmaceutical services. The QI Program concentrates on evaluating both the quality of care offered and the appropriateness of care provided. This will be accomplished through operationalizing the following goals:

- 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 the quality and safety of clinical care, quality of service, and member experience
- Establish timeframes for QI activity completion
- Determine staff members' responsibility for each activity
- Monitor previously identified issues
- Evaluate the effectiveness of the QI Program's Annual Evaluation by comparing performance measure outcomes

- Continuously meet the organization's mission
- Continuously meet regulatory and accreditation requirements
- Create a system of improved health outcomes for the populations served
- Improve the overall quality of life of members through the continuous enhancement of comprehensive health management programs including Quality Improvement Projects
- Make care safer by reducing variation in practice and enhancing communication across the continuum
- Strengthen member and caregiver engagement in achieving improved health outcomes
- Ensure culturally competent care delivery through practitioner cultural education including 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 member safety QI department at **757-252-8400** or toll-free **1-844-620-1015**.

Critical Incident Reporting

A critical incident is defined as any actual, or alleged, event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of the member. Critical incidents are categorized as either quality of care incidents, sentinel events, or other critical incidents as defined below:

- A 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.
- A sentinel event is a patient safety event involving a sentinel death (not primarily related to the natural course of the illness or underlying condition for which the member was being treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury, or the risk thereof. All sentinel events are critical incidents.
- Another critical incident is an event or situation that creates a significant risk to the physical or mental health, safety, or well-being of a member not resulting from a quality-of-care issue and less severe than a sentinel event.

Providers must report critical incidents that occur during:

- The provision of services to members in nursing facilities, inpatient behavioral health or HCBS settings, hospitals, PCP, specialist, transportation, or another healthcare setting
- Participation in or receipt of mental health services, , or services in any
- setting (e.g., adult day care center, a members' home, 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

Provider-Preventable Conditions and Services (Never Events)

- A provider-preventable condition (PPC) means a condition that meets the definition of a "healthcare-acquired condition" or an "other provider-preventable condition" including, but not limited to:
- Wrong surgical or other invasive procedure performed on a patient

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

Serious Reportable Events

Serious reportable events (SREs) are events that are clearly identifiable and measurable, usually preventable, and serious in their consequences, such as resulting in death or loss of a body part, injury more than transient loss of a body function, or assault. These events are adverse in nature and represent a clear indication of a healthcare provider's lack of safety systems.

- Examples of SREs include, but are not limited to, the following:
- Death (patient suicide, attempted suicide, homicide, and/or self-harm while in a healthcare setting)
- Falls (resulting in death or serious injury while being cared for in a healthcare setting)
- Pressure ulcers that are unstageable or stage III or IV acquired post admission/presentation to a healthcare setting
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- Restraint use (physical restraints or bed rails) that results in death, requires hospitalization, or results in loss of function
- Patient death or serious injury associated with patient elopement (disappearance) while being cared for in a healthcare setting
- Abuse/Assault on a patient or staff member on healthcare facility grounds

For a comprehensive list of SREs, please visit this **link**.

Abuse, Neglect, or Exploitation

Mandated reporters are persons who are identified in the Code of Virginia as having a legal responsibility to report suspected abuse, neglect, and exploitation. As defined by the Code of Virginia § 63.2-1606:

- 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 provider 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. The initial report of an incident may be submitted verbally within the 24-hour period but must be followed-up with a written report within 48 hours using the form required below. If the critical incident includes notifying Adult Protective Services (APS) or Child Protective Services (CPS), the following numbers may be used:

Adult Protective Services (APS): **1-888-832-3858**

Child Protective Services (CPS): **1-800-552-7096**

Notify Sentara Health Plans of a critical incident either by phone, fax, or email within 24 hours of knowledge of the incident. Contact information can be found in the "Sentara Health Plans Key Contacts" section.

Sentara Health Plans requires network and/or affiliated providers to report critical incidents via

the Critical Incident Reporting Form located on the Sentara Health Plans website.

Office Site Reviews

Any complaint regarding physical accessibility, physical appearance, adequacy of waiting and examining room space, adequacy of medical/treatment record keeping, and/or accessibility equipment that Sentara Health Plans receive regarding a participating provider is reviewed by the quality department. The Quality Department schedules a site visit with the provider's office within 30 days of the complaint, as warranted. The office site review tool will be utilized for the review, and a letter with the results of the review will be sent to the provider within 30 calendar days of the site visit. If issues are found during the site visit, a Corrective and Preventive Action Plan may be initiated by Sentara Health Plans in its sole discretion.

Medical Record Documentation Standards

Sentara Health Plans may request a provider's 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/NKA on the cover of the medical record is acceptable.

Past medical history (for patients seen three or more times) must be easily identified and include family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunizations, and childhood illnesses.

- Each page of the medical record contains the patient's name or ID number. All entries are dated. Working diagnoses and treatment plans are consistent with medical findings.
- All requested consults must have return reports from the requested consultant, or a phone call follow-up must be noted by the PCP in the progress note. Any further follow-up needed or altered treatment plans should be noted in progress notes. Consultations filed in the chart must be initialed by the PCP to signify review. Consultations submitted electronically need to show representation of PCP review.
- Continuity and coordination of care among all providers involved in an episode of care, including PCP and specialty providers, hospitals, home health, skilled nursing facilities, and free-standing surgical centers, etc., must be documented when applicable.
- There should be documentation present in the records of all adult patients (emancipated minors included) that advance directives have been discussed. If the patient does have an advance directive, it should be noted in the medical record. A copy of the advance directive should be present in the record.
- Confidentiality of clinical information relevant to the patient under review is contained in the record or 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 HIPAA privacy practices.
- An assessment of smoking, alcohol, or substance use should be documented in the record for patients 12 years 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 Medical Record Documentation Standards

- 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.

Medical Record Policies

Participating providers must treat all communications and records pertaining to the member's healthcare as confidential, and no records may be released without the written authorization of the member or as otherwise permitted by state or federal law. As a Covered Entity, Sentara Health Plans may receive member medical records for its operation purposes without a written authorization, as provided under state and federal law. Providers must fulfill valid medical record requests as soon as possible but no later than within 10 calendar days of the date of the record request.

Charging for copies of records:

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

Retention of medical records:

- Providers must maintain records as required by applicable state or federal law but at a minimum of six (6) years from the last date of service of the member.
- Subject to applicable law, if a provider's practice or facility is sold or closed, the provider must notify its patients in writing that it is selling or closing its facility or practice and must state where the records will be located. Providers must also ask patients if they wish to receive their records.
- If the practice or facility is being closed, medical records must be maintained in accordance with the applicable state statute.
- Providers are advised to contact their malpractice insurance carrier to see if they have any additional stipulations regarding medical record retention.

Advance Directives

Sentara Health Plans provides members with information related to advance directives, living wills, appointment of a healthcare power of attorney, and organ donation and anatomical gift designation in compliance with the Patient Self-Determination Act and the applicable state law requiring any service provider to inform adult patients about the laws concerning the patient's rights to accept or refuse care and the right to make advance directives about their care.

Access Advance Care Planning information for Virginia and North Carolina providers from the Sentara Center for Healthcare Ethics is located **here**.

Additional QI Information

To request a copy of HEDIS Performance Measures for Sentara Health Plans, request a hard copy of our clinical guidelines, or ask questions concerning the QI process, please contact the quality improvement department. Current information on **HEDIS measures**, **clinical guidelines**, and **preventive health guidelines** are accessible online.

Office Visit/Encounter Procedures and Member Resources

Member Visit/Encounter Procedure

- Members should present their member ID card and another form of identity verification (e.g., driver's license).
- The provider's staff should check the card for eligibility and benefits and make a copy of the card for the member's record.
- In an emergency, treatment should proceed without question of eligibility or coverage. Eligibility verification can be obtained as soon as appropriate after initiation of treatment.
- The provider's staff should confirm that an authorization for the services to be provided has been received from Sentara Health Plans if necessary under the member's health benefits.
- Provider's staff may access the Avility provider portal anytime or call provider services during business hours for verification if a member's status is in question.

Copayments, Coinsurance, and Deductibles

- Check the member's ID card to determine if there is a copayment due for the specific service rendered. Copayments vary depending on services provided and the member's plan benefits. Some plans do not have copayments. Collect the appropriate copayment from the member.
- The suggested best practice is for providers to submit the claim to Sentara Health Plans first and utilize the Sentara Health Plans remittance to determine the amount due from the member. This process avoids over collecting from members and the additional paperwork and cost of refunding overpayments.
- The member should not pay more than the provider's contracted rate with Sentara Health Plans for the service rendered. If the copayment amount is more than the contracted rate for the service, the member pays the lesser amount of the contracted rate and not the copayment amount.
- A copayment should only be collected for services that are reimbursable under the member's plan.
- Members are responsible for the full plan-contracted allowable amount for applicable visits until their deductible is met if their plan has a deductible.
- Once the deductible is met, members who have plans with coinsurance are responsible for the appropriate coinsurance (percentage of the contracted allowable charge for the visit) unless the member's plan has a reimbursement account funded by the employer to help pay out-of-pocket expenses directly to the provider.
- Providers may elect to collect at the time of service when the member has not yet met their deductible. The amount of the deductible and whether the member has met a portion, or all of the deductibles are usually available through the Availity provider portal or by calling Sentara Health Plans provider services. Member responsibility information will be current as of the time of an inquiry, but if other claims are received and processed before your claim is received and processed, member responsibility could change.
- Providers must reimburse the member any amount collected more than the member's responsibility within 30 days.

- When Sentara Health Plans is the secondary insurance carrier:
  - Do not collect the copayment if the primary payer does not have a deductible.
  - Do not collect the copayment if the member has met the deductible of the primary payer.
  - Collect the copayment if the member has not met the primary payer's deductible.
- Members are notified when they reach their max out-of-pocket (MOOP) and providers should not collect a copayment or coinsurance. It is the responsibility of the provider to refund the member any coinsurance or copayment paid if the member has already met the MOOP. Providers agree to assist Sentara Health Plans to document refunds as part of Sentara Health Plans internal audits, or any audit by a state or federal regulatory body.

Members Rights and Responsibilities

The Member Rights and Responsibilities document assures that all Sentara Health Plans members are treated in a manner consistent with the mission, goals, and objectives of Sentara Health Plans and assures that members are aware of their obligations and responsibilities upon joining Sentara Health Plans and throughout their membership with Sentara Health Plans.

Each Sentara Health Plans product has a specific Member Rights and Responsibilities document that is provided to members at the time of enrollment. The Member Rights and Responsibilities are similar for all Sentara Health Plans products but have slight variations based on variations in the product and the members served by that product. The Member Rights and Responsibilities listed **here** apply to Sentara Health Plans commercial product members (HMO/POS/PPO/Individual). The specific lists of Member Rights and Responsibilities for the other Sentara Health Plans products (Sentara Medicaid program and Sentara Medicare) are provided in the specific provider manual or provider manual supplement for each product.

Special Needs Members

Sentara Health Plans and providers will use all reasonable means to facilitate healthcare services for members with physical, mental, language, and/or cultural barriers. To ensure the needs of members with physical, mental, language, and/or cultural barriers are properly accommodated, members with special needs should be instructed to call member services using the number on the back of their member ID card. Members are notified of these services in their member materials (handbook). If a member services representative needs assistance in accommodating the member, the representative may contact clinical care services (CCS) for additional resources and assistance.

Sentara Health Plans provides appropriate auxiliary aids and services, including interpreters and information in alternative formats, to individuals with impaired sensory, manual, or speaking skills where necessary to ensure equal opportunity to benefits. Communication services for Sentara Health Plans members, potential members, and their companions/family members are provided through a contracted vendor.

Providers requesting translation services should contact provider services to arrange for the member to obtain a hard copy of the material in the primary non-English language or alternative format. The material will be provided on a standing basis, unless otherwise indicated by the member.

Providers should handle interpreter services as follows:

Sentara Health Plans Commercial and Medicare Advantage Members

Providers are responsible for the coordination and payment of interpreter services for their patients, if necessary, as directed by the Americans with Disabilities Act (ADA) and the Civil Rights Act of 1964. Providers can contact Sentara Health Plans provider services for assistance in coordinating (but not reimbursement for) interpreter services.

Essential Community Providers

Sentara Health Plans contracts with available essential community providers (ECPs), such as federally qualified health centers, rural health centers, community health centers, and Indian healthcare providers.

Primary Care Provider (PCP)

Primary Care Provider Panels

Primary Care Providers are required to accept an average of 500 members across all Sentara Health Plans products (per their provider agreement) with which they participate before closing their panels to new members. In addition, providers are required to accept current patients who convert to Sentara Health Plans coverage even if they have reached the 500-member average.

Notification from the provider practice is required for any network panel status change. All changes must be sent online via the **Provider Update Form** on the Sentara Health Plans website.

Please allow up to 30 business days for the requested provider information to be updated in all Sentara Health Plans systems. The requester 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**.

PCP Panel Status Options:

- Open and accepting new members
- Not accepting new patients; provider 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.

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:

- Failure to pay required copayments
- 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. Send a certified letter to the member and state the reason for asking him/her to be repaneled to another provider. State in the letter that the member has 30 days to select a new provider. Inform the member that his/her medical care will continue to be rendered for the next 30 days on an emergency basis only.
2. Send a copy of the letter to your 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.

Health and Preventive 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 - All plan members aged three and over receive a birthday card during their birth month from Sentara Health Plans. Members ages 18 and over receive a bookmark that reminds members of the preventive health guidelines they should follow to achieve their personal best health. The mailing to members ages 3–17 years includes a bookmark with games and puzzles to remind their families to schedule annual checkups. Teen and adult members who have an email address in their profile will receive, instead of the paper card, an electronic birthday message that includes health information as well as links to the Sentara Health Plans website.
- Healthy Pregnancy Mailings - Once the health plan learns of a member's pregnancy, the member receives a letter, a voucher for a healthy parenting magazine subscription, and a magnet featuring the childhood immunization schedule and Sentara Health Plans' wishes for a healthy delivery (sent once member is in the seventh month of pregnancy). Additional mailings are sent throughout the course of the pregnancy and include messages related to preterm labor, stress management, and postpartum check-up reminders.

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 host 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 v 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 is 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've 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.

Health Coaching

Powered by WebMD Health Services (self-funded groups have the option to include this service for a per-member fee)

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.

Resource

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 participate with the Sentara Health Plans physician leadership committee to obtain essential feedback about preventive health practices and recommendations for innovations or revisions in existing services to better meet the needs of health plan members.

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

Awards

In 2023, Sentara Health Plans received Digital Health Awards in two categories for Digital Health Media/ Publications Booklet/Brochure for their "Know Your Numbers" booklet and Web-Based Digital Health Website for their "Stay Smokeless for Life" webpage.

Also in 2023, Sentara Health Plans received platinum-level recognition by the American Heart Association for the Workforce Well-being Scorecard. This program helps employers evaluate the culture of health and well-being within the workforce to identify gaps and determine how their progress stacks up to peer organizations.

Healthcare Services

Healthcare service teams (case management services) are composed of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services.

Types of issues that may be referred to healthcare services:

- Members with complex medical issues who utilize multiple services
- Members who are nonadherent with treatment plans
- Members who frequently utilize services without consulting a PCP or specialist
- Members who frequently utilize the ER
- Members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- Neonatal care for premature and medically complex newborns

Requests for services (written or verbal) may be initiated by:

- Provider
- Member
- Sentara Health Plans
- Authorized representative via the Release of Information (ROI) Form.

To refer members for healthcare services, you may call provider services and be referred to the appropriate team.

Direct phone numbers for case/care management services are listed in the "Sentara Health Plans Key Contacts" section of this manual.

Members are assigned to the healthcare services teams based on their individual medical/behavioral needs and the type of group coverage. The following levels of service are assigned along with goals and outcomes:

- Care coordination
- Case management
- Complex case management: coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services

Clinical Care Services

For all members, the following apply:

- PCP referral is not required for members to access health services.
- Providers may not refer HMO members to out-of-network providers unless authorized by Sentara Health Plans.
- Providers must obtain prior authorization from Sentara Health Plans prior to recommending the member obtain care out-of-network.
- HMO plans may not pay if the services are provided to the member by a nonparticipating provider, except when authorized by Sentara Health Plans.
- Providers must receive prior authorization before services are rendered for any services requiring prior authorization.

PCPs or specialists may not authorize noncovered benefits or out-of-network services unless it is medically necessary and has received prior authorization by Sentara Health Plans.

Exceptions for prior authorization may apply for emergencies and network accessibility.

Behavioral Health Services Access

PCP referral is not required for members to access behavioral health services.

Provider-to-Provider Communication

To ensure continuity of care, the specialist is required to report medical findings to the PCP. The written report must include:

- Diagnosis
- Treatment plan
- Answers to specific questions as the reason for the referral

Second Opinion

Sentara Health Plans covers a second opinion, from a Participating Provider, for treatment options to determine if the service is medically necessary or to explore available treatment options. Members have the option of consulting with an out-of-network provider:

1. Using their out-of-network benefit;
2. At their own expense; or
3. If authorized by the plan

- HMO plans do not cover services provided by a nonparticipating provider unless authorized by Sentara Health Plans.

Medical Clinical Care Services: Prior Authorization

Prior Authorization via the Sentara Health Plans Provider Portal

The preferred method to obtain prior authorization, until this functionality is transitioned to Availity, is through the Sentara Health Plans provider portal.

Prior-Authorization Forms

All prior authorization forms are available on the provider website **here**.

The fax number varies based on the service requested and the member's Sentara Health Plans product type. To ensure your request is not delayed, use the fax number listed on the authorization form for the specific requested service for Commercial or Medicare programs.

Prior authorization is available by phone for medically urgent requests; however, providers are encouraged to use the Sentara Health Plans provider portal whenever possible to expedite the process.

Clinical Care Service Availability

Clinical care service personnel are available between 8 a.m. and 5 p.m., Monday through Friday, Eastern Time. Confidential voicemail is available between the hours of 5 p.m. and 8 a.m., Monday through Friday, and 24 hours on weekends and holidays.

Medicare Prior Authorization

Sentara Health Plans Medicare Advantage HMO and Sentara Community Complete have a dedicated phone number for government programs prior authorization. Please reference the Sentara Health Plans Medicaid Program Provider Manual, Medicare HMO, or Sentara Community Complete provider manual supplements for information specific to the Sentara Health Plans Medicaid Program, Medicare HMO, and Sentara Community Complete policies, procedures, and contacts.

Prior-Authorization Procedures and Requirements

Prior authorization is based on medical necessity as supported by medical criteria and standards of care. Sentara Health Plans does not provide incentives to influence authorization decisions or provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.. Sentara Health Plans Commercial Plans follow the National Committee for Quality Assurance and all other State and Federal regulatory and accrediting guidelines for Timeliness of UM decisions.

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

The requesting provider should receive an authorization for services within 15 days if all the necessary clinical information is 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 pre-authorize services may result in the denial of payment, and the provider may be held responsible for the cost of services rendered.

Please note if the request for services is urgent and requires expedited review.

An expedited review is defined as a request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Prior 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 eligibility for services on the procedure date and benefits provided through the member's health plan.

Except in the case of emergency treatment, prior authorization will be required for:

- All inpatient hospitalizations
- All partial hospitalizations (mental health or substance abuse)
- All outpatient surgeries/short stays/observations and IV therapy and drug infusions
- All skilled nursing facility admissions
- All acute rehabilitation
- All Intensive outpatient programs

- All out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have an out-of-network benefit included in their plan

All the following services require prior authorization regardless of the place of service:

- Commercial plan DME, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates (for Medicare guidance, please reference the appropriate provider manual or provider manual supplement)
- Home health/Hospice/IV infusions
- Plastic and cosmetic treatments and surgery
- All rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.)
- Therapies (PT, OT, ST)
- Applied behavioral analysis
- Early intervention services (part H certification required)
- Transplant services (also applicable when Sentara Health Plans is not the primary payer)
- Human and synthetic tissue
- Oral surgery and related services
- Advanced imaging studies: PET, CT, CTA, MRI, MRA, MR-CT
- Sleep studies performed by a Sentara Health Plans accredited/contracted sleep study provider (requirements may vary for some self-funded groups)
- Hyperbaric therapy
- Electronic bone stimulator
- Any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed
- Injectable drugs indicated on the online prior-authorization forms
- Genetic testing
- Bone densitometry, if less than 24 months since last study

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.

This 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 applies to all Medicare and fully insured members. Self-insured commercial groups may elect to join the program at the time of their benefit renewal. Medical oncology providers should attempt to obtain authorization for services on all Sentara Health Plans commercial members. If a self-insured member has not yet been enrolled in the program, a message indicating the member's enrollment status will be transmitted at the time of authorization entry.

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

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

To authorize admissions:

- Scheduled inpatient admissions: Complete the online request in the Sentara Health Plans provider portal.
- Emergent inpatient admission for a member who is currently hospitalized: Complete the online request form via the Sentara Health Plans provider portal and indicate that it is an urgent request.
- Emergent inpatient admission for a member who has not been admitted: Complete the online form via the Sentara Health Plans provider portal and indicate that it is an urgent request.

Inpatient admissions should be completed online via the Sentara Health Plans provider portal.

The provider or office staff should provide the following information when pre-authorizing services:

- Attending physician's name
- Patient's name, Date of Birth, and member ID number
- Name of rendering facility, agency, or provider
- Date of service
- Diagnosis by name and code
- Service by name and procedure code(s)
- Treatment plan and prior treatment rendered
- Summary of test results (if applicable)

Providers are encouraged to check the Prior Authorization List (PAL) by procedure code before rendering services for commercial and Medicare plans. The PAL can be foun **here**. There may be variation among requirements for commercial employer groups. For questions, please contact **1-800-229-8822**.

Genetic Testing

Providers must obtain a prior authorization from Sentara Health Plans prior to the member receiving services for all genetic testing except NIPT. Testing must be performed at participating specialty laboratories.

Behavioral Health Prior-Authorization Requirement

Routine Outpatient Services

Prior authorization is not required before routine behavioral health outpatient services are rendered by participating providers.

Clinical Care Policies/Criteria

Clinical decisions are based on evidence-based medicine, appropriateness of care, service, and coverage. Sentara Health Plans does not reward denials or provide any financial incentives to achieve underutilization.

Clinical care policies are used to determine medical necessity. Clinical care services develop policies using the following:

- Review of MCG
- Literature review of specialty journals, medical/professional journals, Pub-Med, research studies/outcomes, and articles
- Government regulations and requirements, including LCD and NCD
- Assistance of appropriate network providers/specialists
- Specialty advisors

The medical directors of Sentara Health Plans review clinical care services policies. Approved policies are distributed to all appropriate departments, and all policies are available to providers upon request and available **here**. To request copies of coverage policies and criteria, please call clinical care services.

Pre-Service Review

Medical or behavioral health services requiring elective prior authorization should be submitted as soon as possible or at least 14 calendar days prior to scheduling procedures. This enables the nurse reviewers and medical directors time to review all submitted documentation and request other information or test results to make authorization determinations. These elective decisions will be rendered within 15 calendar days from receipt of all requested information. Urgent cases will be completed within 72 hours.

Admission Review (Medicare)

Clinical care services hospital-review utilization review nurses conduct admission reviews within one working day (within 3 calendar days for

Medicare) of the patient's admission once the authorization request is received. If, at the time of review, there is no record of a preadmission prior-authorization request, Sentara Health Plans will determine if the admission was medically necessary. If the admission was medically necessary, Sentara Health Plans will pay the claim.

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).

Medicare:

Concurrent or continued stay review may be performed, when necessary, on hospitalized members by the hospital utilization review managers. Utilization review nurses may perform a telephonic review and or chart reviews via fax or electronic medical records. If medical necessity for continued hospitalization is uncertain, the medical director may discuss the case with the attending physician (peer-to-peer) at the request of the treating provider.

Post-Service/Retrospective Review

Any service that was not pre-authorized may be retrospectively reviewed. Reviews and decisions will be completed within 30 business days of receipt of all requested information.

Sentara Health Plans Commercial Health Plan Appeals of an Adverse Benefit Determination

This section and process applies to Sentara Health Plans fully insured and self-funded individual and group health plans including HMO, POS, and PPO major medical plans.

Sentara Health Plans has a full and fair internal and external appeal process to review Adverse Benefit Determination.

An Adverse Benefit Determination means that Sentara Health Plans has made a decision not to pre-authorize a covered service, or not to cover or reimburse a post service claim because:

- A member is not eligible for benefits under the plan
- The service, either pre-service or post-service, does not meet our requirements for:
  - medical necessity
  - appropriateness
  - health care setting
  - level of care
  - effectiveness or
- The service is Experimental or Investigational

Providers or members have 180 days from notice of an Adverse Benefit Determination to ask for an appeal. If a provider is submitting an appeal on behalf of a member, Sentara Health Plans may ask the member to sign a form authorizing the provider to act on their behalf. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. Except for urgent situations all appeals must be submitted in writing.

When Sentara Health Plans reviews an appeal,

Sentara Health Plans will look at all comments, documents, records, and other information submitted to the plan. Appeals involving a medical judgment, including whether a particular treatment, drug, or other service is experimental, investigational, or not Medically Necessary will be reviewed by a clinical peer reviewer who did not participate in the first Coverage decision. When Sentara Health Plans completes the appeal, Sentara Health Plans will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include:

1. The specific reason for the decision; and
2. The specific plan provisions Sentara Health Plans based the decision on; and
3. Information on any independent external appeal rights.

Optional Reconsideration of an Adverse Decision

A provider may request a reconsideration of an Adverse Decision on a member's behalf. A request for reconsideration is optional, and available only to a treating health care provider. A provider or member may file an appeal regardless of whether a provider requests a reconsideration. Sentara Health Plans will decide on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. If Sentara Health Plans denies the reconsideration request, the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate recommendation, and appeal rights.

Appeals of Pre-Service Claims

A Pre-Service Claim is a claim for a benefit or service that requires pre-authorization before a member receives care. For Pre-Service Claims, Sentara Health Plans will make a decision and notify the provider and member within 30 calendar days of receipt of written request for the appeal.

Appeals of Post-Service Claims

A Post-Service Claim is any claim for a benefit that is not a Pre-Service Claim. An example would be a claim for payment for a diagnostic test or other services the member has already had done. Sentara Health Plans will make a decision and notify the provider and member within 60 calendar days of receipt of written request for the appeal.

Appeals of Concurrent Claims or Review Decisions

A Concurrent Care Claim is a claim for a benefit where Sentara Health plans is reducing or ending a service previously approved. It can also be a request to extend the course of treatment. An example would be a review of an inpatient hospital stay approved for five days on the third day to determine if the full five days is appropriate. Another example would be a request for additional outpatient therapy visits. For Concurrent Care Claims, Sentara Health Plans will make a decision and notify the provider and member as soon as possible; and prior to the benefit being reduced or terminated.

Expedited Appeals for Urgent Claims

An urgent situation means that the requested medical care or treatment is urgent and using the normal appeal process would:

- Seriously jeopardize a member's life or health; or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment.
- An expedited appeal can be requested by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.
- Sentara Health Plans will make a decision on an expedited appeal and notify the provider as soon as possible, but no later than:
- One business day after Sentara Health Plans receives all information necessary to make a decision; or
- Not later than 72 hours from the receipt of the request.

- Expedited appeals relating to a prescription to alleviate cancer pain will be decided not more than twenty-four (24) hours from receipt of the request.

Adverse Determinations Involving the Treatment of Cancer

If the provider receives an Adverse Determination involving the treatment of cancer the provider is not required to exhaust Sentara Health Plans internal appeal processes before requesting a standard or expedited independent external review.

How to Begin an Appeal:

1. Request forms to start a written appeal by:
    - Downloading the forms at **Sentara Health Plans**
    - Send a fax at **757-687-6232**, **1-866-472-3920** or
    - Send a letter by mail at:
      Sentara Health Plans APPEALS
      DEPARTMENT P.O. Box 62876
      Virginia Beach, VA 23466-2876
2. For an Urgent care appeal, please make sure to explicitly state "expedited appeal" in the request to initiate this process.
3. Completed forms can be returned to Sentara Health Plans. Remember to include all the following with the appeal forms:
    - Member information including name, address, and telephone number, member number and group number
    - The date of service, and place of service
    - The name of the doctor or other service provider
    - The charge related to the service and
    - Any new additional written comments, documents, records, or other information Sentara Health Plans should consider

Provider & Member Medicare Appeals/Reconsiderations

This section provides an overview of the Medicare Appeals and Post-Service Reconsiderations processes, as well as the difference between expedited and standard appeals.

Appeals/Reconsiderations refers to the processes through which providers/members can challenge decisions made by the health plan.

Expedited vs. Standard Appeals

Pre-Service you have the option to request an expedited or standard appeal.

Expedited Appeals

Expedited appeals will be reviewed, and decision made within 72 hours of the expedited appeal request. Member or provider may request an expedited appeal where if Sentara Health Plan were to use its normal appeals procedure for making a decision it would (1) seriously jeopardize the life or health of the member or the ability of the member to regain maximum function; or (2) in the opinion of a physician with knowledge of the member's medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim. If you believe you need an expedited appeal, please contact the Appeals Department at **1-855-813-0349**. If your request does not qualify as an expedited appeal, the standard appeal process will apply. The member shall be notified of the decision via a letter and phone call attempt.

Standard Appeals

Standard appeals will be reviewed, and a decision made within 30 calendar days of the date the appeal is received by the plan for medical care that has not already been received and within 60 days for care that has already been received.

Pre or Current Service Request for Appeal of an Adverse Decision/Denial

When Sentara Health Plan denies a pre-service or current service authorization, both the provider and their patient will receive written notification that includes an explanation about the medical necessity or benefits decision and details on how to appeal. Appeals requests are received by the Appeals & Grievances Department, where they review the request and work with the Clinical Care Services and Benefits Teams to review these and respond to these requests.

For Post-Service requests of an adverse decision/denial for payment, please follow the Provider Reconsideration process by completing and submitting a Provider Reconsideration Form (medical claims). Utilize the **Behavioral Health Provider Reconsideration Form** for behavioral health claims.

Medicare Part C and Part B Appeals Process

Patients may be eligible for an expedited appeal if an emergency medical condition exists, otherwise the standard appeal process will be followed. To start the process download the **Medicare Appeals Packet** or contact member services.

To file an appeal, you must do so within 60 days of the date on the letter about our initial decision. Sentara Health plans may give you more time if you have a good reason for missing this deadline. If the patient/member needs someone to act on their behalf to file an appeal, that person must either have legal authority or be appointed as a designated representative. To have a relative, friend, attorney, doctor, or someone else be appointed as your designated representative, both the member and this person must complete, sign, and return the **Appointment of Representative Form** (CMS 1696).

Who may request an appeal:

Expedited Appeal:

- An enrollee
- An enrollee's representative
- Any physician or staff of physician's office acting on said physician's behalf (e.g. request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the enrollee

Standard Pre-Service Appeal:

- An enrollee
- An enrollee's representative
- Any physician or staff of physician's office acting on said physician's behalf (e.g. request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the enrollee
- Any other provider entity (other than the MA plan) determined to have an appealable interest in the proceeding

To initiate a Medicare appeal:

1. Mail or fax Medicare Appeal request to:

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

   Alternatively, you can fax it to **1-800-289-4970**.

2. Include any relevant information such as the Medicare Appeals Packet, office notes, medical records, physician correspondence, therapy notes, copies of bills, and any additional information you want considered.

Adverse Benefit Determination – Provider Appeals on Behalf of a Member

Providers may appeal adverse benefit determinations on behalf of the member; however, they must indicate that they are appealing on behalf of the member. These member appeals may be filed pre-service, concurrent to, or following services being rendered. Appeals on behalf of the member are processed according to the member appeal process and must include a completed Appointment of Representative Form signed by the member. Expedited appeals do not require an Appointment of Representative Form.

Post-Service Reconsiderations for Medicare

A reconsideration is a written notification from the provider indicating their request to review how a claim is processed. No changes to the claim are being made.

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

Non-par Medicare providers have 60 days from the last claim adjudication date to file reconsideration and must also submit **Waiver of Liability** agreeing not to balance bill regardless of reconsideration outcome. Provider Reconsideration Forms are available on the Sentara Health Plans website or by calling provider services. Online forms are as follows:

Provider Reconsideration Form (medical claims)

Behavioral Health Provider Reconsideration Form (behavioral health claims)

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

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

Partners in Pregnancy - Commercial

The Partners in Pregnancy program is available to commercial members enrolled in all Sentara Health Plans products. Partners in Pregnancy program referrals come from provider offices and member self-referrals, as well as administrative data, to ensure as many members can be reached as possible.

Once a referral has been received, the team reaches out to the member by phone to explain the program. When a member elects to participate in the program, a comprehensive assessment, including an obstetrical assessment, is completed to tailor the program to suit the member's individual needs. Risk stratification is conducted using the assessments to allow members to be assigned to the appropriate Partners in Pregnancy team member. Members who stratify as high-risk are assigned to a registered nurse, and members who stratify as low risk are assigned to care coordinators. Moderate-risk members may have a combination of team member types. The team contacts members at regular intervals during their pregnancy to provide prenatal education and mental health screenings and to answer questions regarding benefits and other available services. The team also includes a licensed clinical social worker who can assist with community resources such as housing, food, etc.

The Partners in Pregnancy team can communicate a member or case manager's concern to a designated person within the provider office to expedite coordination of care. After 60 days postpartum, members who require additional assistance will be referred to other appropriate Sentara Health Plans case management teams for further assistance. The number for Partners in Pregnancy is listed in the "Sentara Health Plans Key Contacts" section at the top of this document.

Patient Access Guidelines

For maternity care, appointments to provide initial prenatal care will be made as follows:

- Within seven calendar days of the request for pregnant enrollees in their first trimester
- Within seven calendar days of the request for pregnant enrollees in their second trimester
- Within three business days of the request for pregnant enrollees in their third trimester or for high-risk pregnancies, or immediately if an emergency exists

Home Health Post-Delivery Services

Home health services are available, with prior authorization, to assess and treat both the mother and child after discharge.

High-Risk Pregnancies

All high-risk pregnancies should be managed by a contracted maternal and fetal medicine specialist (MFM). If you need assistance identifying a contracted MFM specialist, please contact the Partners in Pregnancy case manager.

Dependent OB Coverage

Please call provider services to confirm OB coverage for dependents.

Gynecological Care - Commercial

Annual Gynecological Exams

Annual OB/GYN exams are covered every year, allowing a 45-day grace period for scheduling appointments. This exam includes routine healthcare services rendered during or because of the annual visit. It includes:

- Physical and pelvic exam
- Hematocrit or hemoglobin test
- Pap smear
- Urinalysis
- Wet prep
- Depo-Provera
- Pregnancy testing if medically indicated
- Cholesterol screening
- Mammograms per USPSTF guidelines

Vasectomies and Tubal Ligations

Most plans require copayments for vasectomies and tubal ligations. Call provider services for more plan-specific information. Not all plans cover these services.

Infertility Treatment

Some members do not have infertility benefits in their core coverage. In addition, fertility drugs, in vitro fertilization, services associated with the storage/freezing of sperm, or charges for donor sperm are not covered under most plans. Please call provider services to verify coverage.

Termination of Pregnancy/Abortions

Members may have benefits for elective abortions in the first 12 weeks of pregnancy. If the PCP or OB/GYN does not wish to refer the member, the member may obtain an authorization by calling the prior-authorization number on the member ID card. Please call the clinical care services medical or government programs phone number for a list of providers contracted to provide this service.

Gynecological Care - Medicare

Medicare Part B (Medical Insurance) covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months in most cases. If you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months, Medicare covers these screening tests once every 12 months.

Part B also covers human papillomavirus (HPV) tests (as part of a Pap test) once every five years if the Member is between the ages of 30–65 without HPV symptoms.

Under the Medicare Program guidelines, the coverage of sterilization is limited to necessary treatment of an illness or injury. An example of necessary treatment is the removal of a uterus or removal of diseased ovaries (bilateral oophorectomy) because of a tumor, or bilateral orchiectomy in the case of prostate cancer.

Elective hysterectomy, tubal ligation, and vasectomy in the absence of a disease for which sterilization is considered an effective treatment are not covered. In addition, no payment would be made for sterilization procedures if it is a preventive measure (e.g., a physician believes pregnancy would cause overall endangerment to a woman's health) or as a measure to prevent the possible development of, or effect on

a mental condition, should pregnancy occur.

Abortions are not covered Medicare procedures except:

1. If the pregnancy is the result of an act of rape or incest; or
2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed

For infertility, Medicare pays for certain doctors' services, outpatient care, medical supplies, and some medically necessary fertility treatments, but IVF is not covered.

Emergency Department/Urgent Care Centers

Members do not need prior approval from their PCP or Sentara Health Plans before seeking care at the Emergency Department (ED) or urgent care center (UCC). All members are encouraged to contact their PCP or Sentara Health Plans via the Nurse Advice Line program for instructions on the type of care to receive.

Sentara Health Plans covers any emergency services, that meets the criteria defined under the "Emergency Department Services" section of this manual.

All members seeking care at emergency facilities will be subject to any applicable member cost share.

Nurse Advice Line Program

The Nurse Advice Line provides an avenue of care for members who need treatment or advice after their provider's office is closed. Registered nurses are available to provide direction and education for patients whose needs range from a sore throat to surgery questions. These nurses follow a set of protocols written and approved by physicians in providing educational information.

The nurse will give advice based on approved protocols for self-care or where to seek care based on assessment questions. They may recommend follow-up with a PCP or may refer patients to a facility for evaluation and treatment of symptoms. Members are informed that the nurse does not have access to medical records and does not diagnose medical conditions, order lab work, write prescriptions, order home health services, or initiate hospital admissions.

Benefits

Providers benefit from the program in several ways:

- The member receives advice to meet appropriate healthcare needs.
- The program reduces the number of after-hours nonemergency calls you receive.
- The nurse will contact you if the situation requires it.

Information

Information about the program and how to use it is available from provider services for offices to distribute to patients.

Telephone Number and Hours

Members may be directed to their member ID cards or the member website for telephone contact numbers. The program is available 24 hours a day, 7 days a week.

MDLIVE®

When the member's provider office is closed and the after-hours nurse recommends seeking care other than the provider's office when it reopens, Sentara Health Plans fully insured members, some self-funded groups, and Medicare Advantage program members have access to board-certified physicians through MDLIVE 24 hours a day, 7 days a week by calling **1-866-648-3638** or online.

Members with this benefit can access MDLIVE through online video, phone, or by secure email for a specific listing of complaints. Sentara Health Plans member ID numbers are required for members to register for MDLIVE.

Additional Ancillary Services

Depending on the plan, covered ancillary/other services, such as home health, DME, and prosthetic appliances, require prior authorization. Details are outlined in the information provided below. Review the Sentara Health Plans Medicare provider manual supplements for Medicare information.

Artificial Limb Benefit

Coverage for artificial limbs varies by product and/or employer. Please call provider services to determine coverage and patient cost share for the specific member you are treating, or you may inquire about specific benefit limitations and patient cost share at the time of prior authorization of services. Prior authorization is required.

Audiology Services (Commercial)

Audiology services are covered when authorized by Sentara Health Plans.

Hearing aids for children aged 18 and under are covered under Sentara Health Plans and Sentara Health Insurance Company individual and group fully insured plans. Hearing aids for adults aged 19 and above are covered under some plans through a rider. Members have access to a value-added hearing aid discount program if they use the discount program provider. This value-added hearing aid discount program can be accessed when the member does not have a hearing aid benefit. Please contact provider services for specific coverage.

Chiropractic Services

Some plans and employer groups have chiropractic benefits. Sentara Health Plans has contracted with a vendor to administer the chiropractic benefits as applicable to all plans. A chiropractic provider search feature and additional provider information for the HMO/POS and PPO chiropractic networks are available on the provider website. For authorization, billing, and reimbursement information, refer to the chiropractic vendor guidelines.

Dental Coverage

Accidental Dental:

Treatment of a dental accident is covered as a medical benefit for some members and is separate and apart from any dental plan or dental rider. Specific coverage information and exclusions are available to providers during business hours by calling provider services. A healthcare professional, such as a nurse or a physician, must document treatment. For injuries that happen on or after the member's effective date of coverage, treatment must be sought within 60 days of the accident. Specialist copayments apply to each visit to a dentist or oral surgeon covered under this benefit.

Dental services performed during an Emergency Department visit immediately after an accidental injury in conjunction with the initial stabilization of the injury are covered. Members are responsible for the Emergency Department copayment or coinsurance.

Dental coverage varies by plan type and/or employer group.

Dental Care Discount:

Sentara Health Plans members may receive up to 20% off usual and customary charges for dental services and appliances when receiving services from a participating discount dental care provider. A detailed description of the benefits and exclusions of this program and a listing of discount dental care providers are available on the member website.

Dialysis Services

- A valid written or verbal order from the attending nephrologist is required.
- Dialysis claims must be submitted on a UB-04 claim form.
- Dialysis supplies are only payable in the home setting. Appropriate documentation and
- J-codes are required to differentiate the medication from pharmacy supplies.
- Dialysis claims must indicate the appropriate revenue, CPT codes, and/or HCPCS codes.
- Nonroutine dialysis lab work must be sent to a participating reference laboratory for processing.

Disposable Medical Supplies (Commercial)

- Commercial plans cover ostomy supplies, diabetic supplies, holding chambers (spacer/aero chamber), and peak flow meters. These items may require authorization.
- Other disposable medical supplies are not covered.
- Spacers (which are different than spacing devices) are included with the medication and are not separately reimbursable.
- Insulin pump supplies are not included in diabetic supplies and require authorization.

In summary, all covered disposable supply items (excluding those supplies listed above) that will be separately billed to Sentara Health Plans must be authorized. All covered replacement supply items also require authorization.

Billing and Reimbursement:

If a miscellaneous HCPCS code is billed for an item when a specific HCPCS code exists, the item will be denied with comments stating to resubmit the claim with specific HCPCS codes.

DME (Commercial)

DME includes equipment or items, which can be purchased or rented, which are able to withstand repeated use, which are medically necessary, and which are typically used in the home. Some supply items that fall under the DME category are covered services and typically require prior authorization. Most products have a calendar year benefit maximum. Contact provider services for specific member benefit information. Utilization management (UM) will assign authorizations for DME services that require authorization.

Authorizations are issued for medical necessity but do not guarantee payment.

DME Equipment Rental and Purchase Policy

The following applies to commercial and program plans:

- Sentara Health Plans clinical care services will determine if equipment being rented should be converted to purchase within the first three months of rental.
- Should accumulated rental payments exceed 110% of the purchased price of the equipment, Sentara Health Plans considers the equipment purchased, and all rental payments are stopped.
- If equipment is being rented and subsequently purchased, all accumulated rental payments are offset against the purchase price; only the difference is paid, and the equipment is considered purchased.
- All equipment rentals must be billed in monthly increments (except codes E0935 RR – CPM

Machine and E0202 RR – phototherapy blanket rented daily). The appropriate date range and a quantity of 1 (one month's rental) should be indicated on the claim form.

- Sentara Health Plans follows CMS units of measure for all rentals.

Equipment Rental Payment When a Member Becomes Disenrolled

If Sentara Health Plans determines that a member became disenrolled during the period covered in the date range, Sentara Health Plans will process the claim as indicated below:

- The line item billed will be changed to indicate the dates the member was covered by Sentara Health Plans.
- A quantity of one will be shown for the covered days, and the full month's rent will be paid.
- A second line item will be added indicating the dates the member was not covered by Sentara Health Plans.
- A quantity of zero will be shown for the noncovered days and an adjustment code, D28, indicated with a comment: "Member disenrolled on XX date, full month rental payment made."

DME Copayments/Coinsurance

Copayments vary by product and employer. Please contact provider services for details.

DME Service/Maintenance on Purchased Items

Service/maintenance of purchased items requires prior authorization.

Commercial Lines of Business:

- Providers must bill with the appropriate HCPCS code for the purchased item and append the "MS" modifier.
- Sentara Health Plans allows for reimbursement of maintenance/service once every six months for parts and labor items that are no longer under warranty.

Sentara Health Plans Medicaid program follows DMAS requirements for billing of E1399 with an English description.

DME Miscellaneous Codes

Digital hearing aids, custom and power wheelchairs, and wheelchair accessories with no established allowance will be reimbursed based on invoice. An invoice must be submitted with the claim for the equipment to be reimbursed.

Employee Assistance Program (EAP) Services

All behavioral health providers who participate with Sentara Health Plans commercial products (fully insured, self-insured, commercial, HMO, POS, and PPO) are contractually obligated to provide services for the employee assistance program (EAP), per Exhibit E-1 of the Sentara Health Plans Behavioral Health Provider Agreement, unless there is a qualified written exception.

A provider's assessment and referral of EAP services include:

- Diagnostic assessment
- Intervention and/or short-term counseling
- ▪Referral to appropriate local resources

Providers will receive EAP referrals from employees of Sentara Health Plans. Appointments should be offered within 48 hours of the referral with a face-to-face assessment at that time unless a later date is requested. Sentara Health Plans EAP will send a detailed provider packet via secure email or fax that includes all forms required for case documentation and reimbursement.

Home Health and IV Therapy (Commercial)

Home health and IV therapy services require prior authorization for all products. To arrange and obtain prior authorization for home health or IV therapy services, enter the request via the Sentara Health Plans provider portal, until this functionality is available in Availity. Change requests for authorizations must be faxed to clinical care services within 60 days of the original authorization for Medicare plans.

Home health benefits are not payable for custodial

care. Custodial care is defined as "treatment or services designed mainly to help the patient with daily living activities." These activities include help with walking, getting in and out of bed, bathing, preparing meals, acting as a companion, etc.

For all products, therapy services (physical, occupational, or speech) provided in the home setting will have a copayment applied for each modality provided during the visit as defined by the plan. No supplies or pharmacy items should be billed in conjunction with therapy services.

Standard supplies are included in the skilled nursing visit. Extensive supplies used in conjunction with an authorized skilled nursing visit for wound care services are reimbursable at contracted rates if specifically authorized by clinical care services.

Hospice Services (Commercial)

Hospice care is available to members who are diagnosed with a terminal illness and have fewer than six months to live. Hospice care services (revenue code 651) include:

- Care of the member and the family as a unit
- Palliative care (relief of pain) rather than curative measures
- Bereavement counseling
- Pastoral services

The members must elect the hospice program. Following the member's election, all hospice care must receive prior authorization by clinical care services.

Medical Transportation Services/Ambulance

Non-Emergent Transport

- Medicare members are eligible for nonemergent transport through their health plan benefits.
- Members can call their care coordinator to set up transportation or call the number on the back of their health insurance card

Ambulance transportation by stretcher and wheelchair transportation services that are not emergency services must be pre-authorized by Sentara Health Plans. We will not cover transportation that is not required by the person's physical or mental condition. Transportation from hospital to hospital may be covered if medically necessary and pre-authorized by Sentara Health Plans.

Emergency Transport

- In an emergency, Sentara Health Plans will cover ambulance services from the home or the place of injury or medical emergency to the nearest hospital where appropriate treatment can be provided. Medical Necessity would not apply.
- Ambulance/stretcher transportation from facility to facility must receive prior authorization through the health plan.
- Members are responsible for copayments each way for ambulance services. This applies to both emergent and nonemergency services.
- Ambulance providers must obtain prior authorization for applicable services whenever possible for all products. In cases requiring services after routine business hours or other circumstances where services were provided in good faith, Sentara Health Plans will not withhold authorization if the patient is a current Sentara Health Plans member, medical necessity warrants the services, and the authorization request is made within 30 days of the service.

Air Ambulance Services (Commercial)

Please note the following about air transportation benefits under Sentara Health Plans:

- For covered emergency or nonemergency air ambulance services from out-of-network providers, members are responsible for in-network copayments, coinsurance, and deductibles listed on Sentara Health Plans' Schedule of Benefits. Member cost sharing will be applied to in-network maximum out-of-pocket amounts listed on Sentara Health Plans' Schedule of Benefits. Members are protected from balance billing for air ambulance services received from out-of-network providers.
- Benefits are available for air emergency transportation when using a ground ambulance would endanger the member's health and

the medical condition requires more urgent transportation to an acute care hospital than a ground ambulance can provide.

- Benefits include air transportation to the closest hospital that can treat the member.
- Transportation or transfer by air ambulance from one hospital to another hospital is only a covered service when the member's condition requires certain specialized medical services that are not available at the hospital that first treats the member and using a ground ambulance would endanger the member's health.
- Transportation or transfer by air is not a covered service just because the member, the member's family, or provider prefer the member receive treatment by a specific provider or at a specific hospital.
- Air ambulance is not covered for transportation to other facilities such as a skilled nursing facility, a doctor's office, or a member's home.

Please reference the Sentara Health Plans Medicaid Program Provider Manual for Medicaid program-specific transportation policies and procedures.

Nutritional Counseling/Dietician

Coverage is limited to medically necessary conditions that must be managed by nutritional assessment or behavior modification.

These include but are not limited to:

- Pregnancy
- Diabetes mellitus
- Morbid obesity
- Heart disease
- Hyperlipidemia
- Obstructive sleep apnea
- Mental health diagnosis of an eating disorder

All plans will cover diet evaluation and instruction by a contracted dietician or physician. The patient is responsible for office visit copayments each session.

Oxygen Policy

Members may receive oxygen through a DME/respiratory therapy provider. Oxygen services are paid as a medical benefit rather than a DME benefit. DME maximum benefit limits do not apply. For all products, oxygen therapy receives prior authorization by clinical care services based upon diagnosis and medical necessity. For all products, oxygen services require a physician order and oxygen saturation level meeting medical criteria. All supplies are included in the rental reimbursement.

Continuation of oxygen usage by a member requires the provider to submit yearly oxygen saturation levels to clinical care services, except for patients with chronic conditions. All oxygen and oxygen equipment must meet the criteria for medical necessity as defined by clinical care services.

All requests for liquid oxygen will require the ordering physician to submit the medical necessity ordering form/oxygen and must be approved by Sentara Health Plans' medical director.

Initial authorizations will be set up for either three months or one year depending on the episode of illness. Oxygen systems do not fall under the rental-to-purchase procedure.

Physical and Occupational Therapy

Outpatient physical and occupational therapy are covered services when medically necessary and authorized by Sentara Health Plans' clinical care services. Outpatient physical and occupational therapy may be performed by participating therapy providers meeting Sentara Health Plans' therapy participation criteria. All therapy providers must complete the physical therapy provider participation criteria and licensure/malpractice verification requirements attesting that they meet Sentara Health Plans' therapy criteria and agree to comply with all participation requirements and pass the Sentara Health Plans self-assessed physical therapy provider office site evaluation. For purposes of this section, the term "therapy provider" includes freestanding and hospital-based therapy centers.

The following therapy guidelines are applicable to all therapy providers:

- Coverage of therapy services varies by plan type and employer. Verification of therapy benefits

for a specific member may be obtained by contacting provider services.

- Reevaluations are not covered by Sentara Health Plans.
- Work-hardening programs or functional capacity testing is not covered by any plan.

Ordering and Authorization Process:

- All therapy services must be ordered by a physician. A PCP or specialist may order therapy services by providing the member with a written prescription for therapy services to a participating therapy provider.
- The participating therapy provider or facility can perform the evaluation without an authorization. Following the evaluation, the therapy provider or facility must contact clinical care services to obtain authorization.
- Upon completion of the evaluation, the therapy provider should proceed as follows:

1. The therapy provider must complete an authorization request for an Outpatient Physical Occupational-Speech Therapies via the Sentara Health Plans provider portal, until this functionality is available in Availity, for members of commercial plans.

2. Clinical care services will process and return the authorization request for Outpatient Physical Occupational-Speech Therapies form to the therapy provider indicating the authorization number, the number of visits authorized, the modalities, and the time frame. If a treatment was provided in addition to the evaluation during the initial visit, that treatment must be indicated on the authorization request Outpatient Physical Occupational-Speech Therapies form. Clinical care services will then determine if the treatment performed during the initial visit will be covered.

   The therapy provider will use the Sentara Health Plans provider portal, until this functionality is available in Availity, to request additional visits or make changes to the treatment plan.

Billing and Reimbursement:

- Freestanding therapy providers should submit claims electronically on a CMS-1500 claim form using the appropriate CPT codes, as designated by the current AMA CPT code book.
- Hospital-based therapy providers should submit claims on a UB-04 claim form using the revenue code 42X for physical therapy and revenue code 43X for occupational therapy. In addition to the revenue code, the appropriate CPT codes, as designated by the current AMA CPT Code book, must be included.
- Procedure code 97750 (physical performance measurement, with written report, each 15 minutes) is covered and may be billed by a therapy provider to render an initial evaluation of the member at the initial visit. This code is billable in 15-minute increments.
- Customized splints provided by the therapy provider must receive specific prior authorization by clinical care services for all plans. The customized splint must be billed using the appropriate HCPCS code.
- Therapy codes apply one copayment per visit (date of service) for each modality of therapy provided.

Prosthetics and Orthotics (Commercial)

Prosthetics and orthotics are covered when determined to be necessary and appropriately pre-authorized by Sentara Health Plans' clinical care services. Customized and non-customized single orthotics with requested charges equal to or greater than $750.00 must be authorized for commercial plan members. Authorization limit amounts may differ for some self-funded groups. Providers should call provider services to determine authorization requirements for self-funded groups. For Medicaid and Medicare guidance, please reference the appropriate provider manual or provider manual supplement. Coverage for nonsurgical implanted prosthetics and orthotics combined is limited to the member's benefit limit per calendar/contract year and to those conditions resulting from injury or illness while a member is covered. Please contact provider services to determine the member's coverage.

Prosthetics and orthotics are covered as follows:

- Purchase of the initial device for conditions resulting from illness or injury while a member is covered
- Replacement prosthesis for a growing child up to age 18 who may or may not have been continuously covered when the illness or injury occurred and the initial prosthesis was fitted
    - Replacement is covered due to growth and surgical revision of an amputation.
- Breast prosthetics
- Two prosthetic bras for members with a cancer diagnosis

Coverage does not include:

- Repairs to or replacement of a prosthesis that an adult member received prior to enrollment
- Replacements due to weight gain or loss or shrinkage of the appendage

Skilled Nursing Facilities (SNFs)

Placement in a skilled nursing facility requires prior authorization.

Sleep Studies

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

Speech Therapy

- Speech therapy services require prior authorization by clinical care services for commercial plans.
- Speech therapy may be performed by participating providers, therapy centers, or hospitals contracted to perform speech therapy.
- Verification of therapy benefits for a specific plan may be obtained by contacting provider services.
- Regardless of place of service, deductibles/ coinsurance or copayments are required for therapy services, per visit, per therapy type for commercial plans.

Vision Coverage

Preventive Vision Coverage

For most benefit plans, members receive preventive vision benefits through the Sentara Health Plans' vision vendor. Preventive vision services are not reimbursed under Sentara Health Plans and should be obtained by members through their vision vendor (or if applicable, other employer-specific) vision benefits.

Vision Benefit

Each covered individual may receive an eye exam (at a plan-specific copayment) every 12 or 24 months, depending on the member's vision benefit.

This includes:

- Case history: pertinent health information related to eyes and vision acuity test, unaided and with previous prescription
- Screening test: for disease or abnormalities, including glaucoma and cataracts

Diabetic Dilated Eye Exam Exception

For members with diabetes, regardless of the benefit plan, dilated retinal eye exams are covered every 12 months without a referral. These screening exams may be obtained through the vision vendor or participating ophthalmologists or optometrists.

Accessing Benefits

Members should first call the member services number on their member ID card for details.

Members should call their vision vendor for an appointment and provide their member ID number for identification. Members may select a provider by going to the member website.

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

Exclusions

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
- Corrective eyewear required by an employer as a condition of employment and safety
- Eyewear, unless specifically covered under plan
- Services provided as a result of any worker's compensation law
- Discount not available on frames where the manufacturer prohibits a discount

Vision Materials Supplement

Groups electing the vision materials supplement coverage have a benefit for expanded optical care service. The member may be responsible for a plan-specific copayment for the materials in addition to the exam copayment.

Discount Schedule

Members may be able to obtain discounts or exams and vision materials by selecting vision under the portal for more information.

Pharmacy Services

Pharmacists as Providers (for commercial plans, not applicable to Medicare)

In accordance with the provisions of § 54.1-3303, Virginia law allows pharmacists to initiate treatment with, dispense, or administer certain drugs and devices to commercial plan 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 Virginia Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health and set forth in regulations of the Board.

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

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

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

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

To provide medical services, pharmacists must meet Sentara Health Plans contracting and credentialing requirements. Pharmacists acting as providers are also responsible for adhering 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 **here**.

Pharmacy Program

Sentara Health Plans manages the pharmacy program by evaluating the safety, efficacy, and cost-effectiveness of drugs. A Pharmacy and Therapeutics (P&T) Committee, consisting of pharmacists and physicians representing different specialties, review the clinical appropriateness of drugs for inclusion in the formulary. The P&T Committee also reviews and approves the clinical criteria for drugs with utilization management programs such as prior authorization (PA), step therapy (ST), and quantity limits (QL). A team of pharmacists at Sentara Health Plans is responsible for drug coverage and formulary management decisions with the guidance provided by the P&T Committee.

Our formularies are developed with the inclusion of key agents within selected therapeutic classes. These agents offer comparable safety and efficacy yet are more cost-effective than similar agents. Sentara Health Plans formularies are available on our website. Notification of changes to the formulary appear in the Sentara Health Plans provider newsletter, with a link to the formulary changes on the provider website.

Members may enroll in plans that do not include a pharmacy benefit. The member's ID card will identify pharmacy benefits under the "Rx" section, which will include their cost share for covered drugs.

Sentara Health Plans Formularies

Sentara Health Plans offers the following prescription formulary programs for our commercial members:

- Sentara Open Formulary for self-funded, **Business*EDGE***®, and large group plans
- Sentara Standard Formulary for self-funded and large group plans
- Sentara Standard Formulary for small group plans
- Sentara Individual & Family Health Plans Formulary
- Federal Employees Health Benefits Program Formulary
- City of Suffolk Formulary
- Virginia Commonwealth University Health System Authority Formulary

Sentara Health Plans Open Formulary covers many medications unless there are benefit exclusions. This allows for the accessibility of multiple medications within a class and permits members and providers to determine the medication that is best for the individual member.

Sentara Health Plans standard and small group plans formularies cover select medications within each therapeutic drug category that have been reviewed by the P&T Committee. In addition, Sentara Health Plans' small group plans formulary meets the state regulatory agency's (such as the Virginia Bureau of Insurance) benchmark. Members may request an exception for a drug that may not be included on the formulary.

Our formularies require generic drug prescription usage whenever possible. These drugs are listed with the generic name on the formularies. If a member requests a brand-name drug when a generic drug is available, the member may be responsible for additional charges.

Tier Formulary Copayment Structure (Commercial Plans)

All covered drugs, including specialty drugs, are placed in one of four tiers for our commercial formularies. Copayments are dependent on both the member's pharmacy benefit structure and the tier in which the prescription drug falls. It is important for the member and provider to work together to determine which drug is appropriate.

- Preferred Generic (Tier 1): Medications on this tier have the lowest member cost sharing amount and include commonly prescribed generic drugs. Brand drugs may be included in Tier 1 if Sentara Health Plans recognizes that they show documented long-term decreases in illness.
- Preferred Brand and Nonpreferred Generic (Tier 2): Includes brand-name drugs and some generic drugs with higher costs than Tier 1 generics, which are considered by Sentara Health Plans to be standard therapy.
- Nonpreferred Brand (Tier 3): Includes brand name drugs not included by Sentara Health Plans on Tier 1 and Tier 2.
- Specialty (Tier 4): Includes those drugs classified by Sentara Health Plans as specialty drugs. Tier 4 also includes covered compound prescription medications. For more information, reference the specialty drug section below.

Utilization Management Program

Sentara Health Plans' clinical staff, along with the P&T Committee, may require utilization management edits prior to coverage or reimbursement for the drug. These edits include prior authorization, step therapy, and/or quantity limits. The formulary, which is available on the provider website, will indicate if a covered drug has any restrictions, or providers can refer to the online drug search tool that is available on the Sentara Health Plan's website.

- Step therapy is a process to ensure that Sentara Health Plans preferred medications are used as the first course of treatment. If the preferred medication is not clinically effective or if the member has side effects, another medication may be used as the second course of treatment. Sentara Health Plans utilizes claim history for approval of second-course treatments at the point-of-sale. Step therapy protocols are based on current medical findings, FDA-approved drug

labeling, and drug costs.

- Quantity limit restricts the quantity of a drug that is covered within a given time. This helps ensure the safety of our members by preventing high and/or inappropriate doses of medication at the point of sale. The quantity limits placed on medications are based on recognized standards of care, such as FDA recommendations for use, and may be periodically updated.
- Prior authorization requires prescribing physicians to send clinical documentation as part of the medical necessity request. Prior authorizations are placed for selected medications that have specific indications for use, are high in cost, or have increased safety concerns.

A request for approval of a drug with utilization management edit(s) may be obtained by filling out the specific prior-authorization form for the medication. These forms may be completed by an office staff member but must contain an original prescriber signature. For copies of the forms, go to the provider section of the provider website or call pharmacy authorizations at clinical care services.

An exception request can be made by the provider, on behalf of the member, by either:

- Calling the pharmacy provider services
- Faxing an exception request form along with clinical evidence to pharmacy provider services

Formulary prior authorization responses are generally received within two working days of Sentara Health Plans receiving the completed form and information from the provider.

Mail Order Prescription Drug Program

Commercial and FAMIS members (excluding Medicaid plan members) have the option of filling certain medications from a mail-order pharmacy. Members may purchase a 35 to 90-day supply of drugs from Express Scripts mail services.

Exceptions to the 90-day supply allowance are specialty medications and opioid pain management medications, which are limited to a 30-day supply.

Members can register for Express Scripts by signing into the **member portal**.

Physicians can submit the prescription electronically to Express Scripts or contact them via phone.

For contact information on the mail order program, please reference the "Sentara Health Plans Key Contacts" section at the beginning of this document.

Diabetic Supplies

Diabetic testing supplies may be covered under the member's pharmacy benefit. This allows members to buy their diabetic supplies from a local, in-network retail pharmacy or through an in-network mail-order pharmacy. For members opting to utilize mail order, you may call Edgepark Pharmacy at **1-877-852-3512** to provide a telephonic prescription.

Members should contact their member services department for more information about their diabetic testing supply coverage.

Injectable and Infusion Medications Administered in the Physician's Office

Sentara Health Plans has an agreement with Proprium Pharmacy to fill and deliver injectable and infusion medication orders for administration in the physician's office. Proprium Pharmacy is a mail-order specialty pharmacy that provides certain prescription medications and immunizations directly to physician offices. Delivery to the physician's office is generally received within 24 hours of submitting the prescription order.

A 20% coinsurance may apply to certain drugs requiring prior authorization. The prior authorization requirements also apply when using Proprium Pharmacy. Medications that are administered in the physician's office that require prior authorization are listed on the Sentara Health Plans injectable and infusion medication list on the provider website.

Proprium Pharmacy bills Sentara Health Plans directly for the medication. The physician's office should only bill for the administration of the medication and should not collect copayments or coinsurance associated with the medications

from patients. Proprium Pharmacy will bill the member for the coinsurance or copayment amount. Proprium Pharmacy may be reached by calling **1-855-553-3568**. Specialty resources are available to providers on the provider website.

Providers may also bill Sentara Health Plans for pre-authorized injectable and infusion medications obtained from other sources by submitting the appropriate J-code. When billing Sentara Health Plans directly for the cost of the medication, providers will be responsible for collecting any coinsurance amount due from the member when the remittance is received.

Limited Distribution Drugs

Manufacturers are increasingly limiting the distribution of specialty drugs to certain pharmacies. Instructions and ordering forms will be distributed to providers by Sentara Health Plans to facilitate continuity of care when this occurs. Sentara Health Plans will notify providers of limitations by mail, email, newsletters, and postings on the provider website.

Specialty Drugs

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

Specialty drugs include the following:

- 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
- Medications subject to restricted distribution by the FDA
- Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy

Specialty drugs are available through the specialty mail-order pharmacy, Proprium Pharmacy. Please reference the "Sentara Health Plans Key Contacts" section for Proprium Pharmacy contact information.

Pharmacy Coverage Exclusions

The following is a list of products or categories that are not covered for reimbursement under the member pharmacy benefit contract. Benefits for self-funded plans may vary, and coverage should be verified for self-funded plans **here**. This list is subject to periodic review by Sentara Health Plans and therefore may not be a complete listing of products.

Prescriptions for the following are excluded from coverage:

- Medications that do not meet Sentara Health Plans' criteria for medical necessity are excluded from coverage.
- Medications with no approved FDA indications are excluded from coverage.
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from coverage and do not count toward any Sentara Health Plans maximum out-of-pocket limit.
- All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a physician's authorization by state or federal law are excluded from coverage.
- Nondurable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from coverage.
- Immunization agents other than those covered by the formulary, biological sera, blood, or blood products are excluded from coverage.
- Injectables (other than those self-administered and insulin) are excluded from coverage unless

authorized by Sentara Health Plans.

- Medication taken by or administered to the member in the physician's office is excluded from coverage unless authorized by Sentara Health Plans.
- Medication taken or administered in whole or in part while a member is a patient in a licensed hospital is excluded from coverage.
- Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from coverage.
- Medications for indications and/or dosage regimens determined by Sentara Health Plans to be experimental are excluded from coverage.
- Therapeutic devices or appliances, including but not limited to support stockings and other medical/nonmedical items or substances, regardless of their intended use, are excluded from coverage.
- Drug charges exceeding the cost for the same drug in conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from coverage.
- Drugs with a therapeutic over-the-counter (OTC) equivalent are excluded from coverage unless authorized by Sentara Health Plans.
- Certain off-label drug usage is excluded from coverage unless the use has been approved by Sentara Health Plans.
- Compound drugs are excluded from coverage when alternative products are commercially available.
- Cosmetic health and beauty aids are excluded from coverage.
- Drugs purchased from non-participating providers over the internet are excluded from coverage.
- Drugs purchased through a foreign pharmacy are excluded from coverage unless approved by Sentara Health Plans for an emergency while traveling out of the country.
- Nutritional or dietary supplements, including but not limited to medical food, food or formula products, or other nutritional or electrolyte supplements are excluded from coverage under the pharmacy benefit.
- Drugs not meeting the minimum levels of evidence based on one or more of the following standard reference compendia are not covered services:
  - American Hospital Formulary Service Drug Information
  - National Comprehensive Cancer Network's Drugs & Biologics Compendium
  - Elsevier Gold Standard's Clinical Pharmacology
- Minerals, fluoride, and vitamins are excluded from coverage unless determined to be medically necessary to treat a specifically diagnosed illness or when included under ACA recommended preventive care.
- Pharmaceuticals approved by the FDA as a medical device are excluded from coverage.
- Raw powders or chemical ingredients are excluded from coverage unless approved by Sentara Health Plans or submitted as part of a compounded prescription.
- Sexual dysfunction drugs to treat sexual or erectile problems are excluded from coverage.
- Infertility drugs are excluded from coverage.
- Prescription or over-the-counter appetite suppressants and any other prescription or over-the-counter medication for weight loss are excluded from coverage.
- Digital therapeutics, including digital devices, software, and applications are excluded from coverage.
- Refills one year after the date of the original prescription.
- Administration charges for the administration of any drug, except for approved covered immunization.
- Charges for the delivery of prescription drugs.

Additional Pharmacy Policies

- Members may have transition of care benefits for certain medications when they are newly enrolled. Transition of care information is available to members by calling member services.
- Benefits will not be denied for any drug

prescribed, on an inpatient or outpatient basis, to treat a covered indication so long as the drug has been approved by the FDA for at least one indication, and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

- Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the FDA for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the FDA for use in the treatment of cancer pain because the dosage is more than the recommended dosage of the pain-relieving agent if the prescription has been prescribed for a person with intractable cancer pain.
- At its sole discretion, the Sentara Health Plans Pharmacy and Therapeutics Committee determines which tier a covered drug is placed in. The Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee reviews the medical literature and then evaluates whether to add or remove a drug from the preferred drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish utilization management edits (e.g., prior authorization, step-edits, quantity limits) for selected medications.
- Amounts the member pays for any outpatient prescription drug after a benefit limit has been reached, or for any outpatient prescription drug that is excluded from coverage, will not count toward any plan maximum out-of-pocket amount.
- Prescriptions may be filled at a Sentara Health Plans pharmacy or a nonparticipating pharmacy that has agreed to accept as payment in full reimbursement from Sentara Health Plans at the same level as Sentara Health Plans gives to participating pharmacies.
- Sentara Health Plans may approve coverage of limited quantities of an OTC drug. You must have a physician's prescription for the drug, and the drug must be included on the member's Sentara Health Plans formulary.
- Insulin, syringes, and needles are covered. Diabetic supplies and equipment and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law, other than those listed as covered under the prescription drug rider are covered under Sentara Health Plans' medical benefit. Any plan maximum benefit does not apply to physician-prescribed diabetic supplies covered under the medical benefit.
- Intrauterine devices (IUDs), implants, and cervical caps and their insertion are covered under Sentara Health Plans' medical benefits.
- Written outpatient drug prescriptions must be executed on tamper-resistant prescription pads.

Additional Medicare Pharmacy information can also be found in the Provider Manual Supplements on the **provider website**.

Laboratory Services

Laboratory services may only be performed by contracted lab providers. Any entity providing laboratory services must have the appropriate CLIA certificate.

In-Office Lab

Sentara Health Plans reimburses providers for certain specific lab tests performed in the provider's office. The most current list of services that will be reimbursed by Sentara Health Plans when testing is performed in the provider's office can be located **here**.

In addition to the in-office lab list, a limited number of specialty-specific lab tests may be performed in certain specialty offices. Your network educator will provide you with details for your specialty. These specialties include:

- Dermatology
- Endocrinology
- Hematology/Oncology
- Infectious disease
- Nephrology
- OB/GYN
- Ophthalmology
- Urology
- Reproductive medicine
- Rheumatology

The in-office lab list is applicable to medical providers only and does not apply to behavioral health providers.

All other testing must be performed by a participating reference lab. Sentara Health Plans will reimburse providers for the draw fee. Charges from providers for lab tests other than the ones listed above will be denied as a non-allowable lab charge, and the member may not be held responsible.

Sentara Health Plans does not provide additional reimbursement to participating reference labs for the draw/collection.

Certain highly specialized lab tests may be available only from a few labs. Some exceptions apply to providers located in specific geographic areas. Please contact your network educator for guidance in these cases.

In-Office Laboratory Services Reimbursement

- The office may bill one venipuncture fee per patient.
- Samples obtained by swab or cup are part of the office visit.
- Sentara Health Plans will not reimburse CPT code 99000 as a handling or draw fee.
- Sentara Health Plans will not reimburse CPT codes billed individually when they are considered part of a bundled CPT code.

Reference Lab Providers

Any lab test not included on the "in-office lab" list must be sent to a participating reference lab. Participating reference laboratory providers are listed on the provider website under the provider search option.

Laboratory Draw Sites

Providers have the option of sending the patient with orders to a participating reference laboratory draw site. Members and providers may locate the nearest participating laboratory draw site by using the provider search option on the provider website or by calling provider services. Since locations and providers are subject to frequent additions and changes, the most reliable locator for current information is on the provider website.

Preoperative Lab and X-ray

Members scheduled for surgery at a participating hospital may obtain services through a participating reference lab or may be sent directly to the admitting participating hospital with a prescription

for preoperative testing.

If surgery is scheduled with fewer than three days' notice, the lab testing should be performed by the admitting hospital.

Toxicology Lab Services and Medication Compliance Testing

Aegis Sciences Corporation provides in-network toxicology lab services for all Sentara Health Plans service areas. In-depth medication compliance services, including pain management and substance use testing, are available for Sentara Health Plans medical and behavioral health providers for all Sentara Health Plans products.

Reimbursement

Sentara Health Plans follows American Medical Association (AMA) coding guidelines (e.g., CPT and HCPCS definitions) and health plan policy, as well as Medicare policies and procedures, to include the most current Correct Coding Initiative (CCI) edits when making claims payment determinations with respect to the following:

- Bundling/Unbundling
- Anesthesia included in surgical procedure
- Separate procedure definitions
- Most extensive procedure
- Sequential procedures
- Mutually exclusive procedures
- Misuse of component codes with comprehensive codes
- Standard preparation/monitoring services
- Standards of medical/surgical practice
- Laboratory panels

The above list is not meant to be all-inclusive but represents major categories of edits where Sentara Health Plans routinely uses Medicare rules as its basis. Sentara Health Plans may utilize proprietarily purchased software products that incorporate similar coding and compliance rules into Sentara Health Plans' claims processing edits.

Clear Claim Connection (C3) is a web-based code-auditing reference tool that enables Sentara Health Plans to disclose code-auditing rules and associated clinical rationale. Medical providers can enter outpatient claim information using CPT and/or HCPCS codes, obtain audit results, and review recommendations. Clear Claim Connection is available to medical providers through the Sentara Health Plans provider portal and on the provider website. Medicare policy and procedural information is available at **cms.gov/**.

The CMS website can give your practice information regarding Medicare's National Correct Coding Initiative (NCCI) edits and how to go about obtaining those edits.

Provider Fee Schedule

Provider compensation arrangements and rates are detailed in your provider agreement. Information and current policies for developing fee tables and gap-filling fees for existing codes or assigning fees to new codes may be obtained by contacting your contract manager.

Billing and Payments

Contracted Amounts/Billing Covered Persons

By entering into a provider agreement, the provider has agreed to accept payment directly from Sentara Health Plans. This constitutes payment in full for the covered services the provider renders to members, except for copayments, coinsurance, deductibles, and any other monies listed in the "patient responsibility" portion of the remittance advice. The provider may not bill members for covered services rendered or balance bill members for the difference between the 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 the provider collect more than the allowed amount, the provider will be expected to refund the member the difference between the two amounts within 30 business days after receipt of the excess amount, unless a shorter timeframe is required by law.

Commercial Balance Billing (Protection from Surprise Medical Bills "No Surprises Act")

The following services from in-network or out-of-network providers are covered under in-network benefits; and members are protected from balance billing:

- Emergency services at a hospital or freestanding emergency facility. This also includes post-stabilization services, including any additional covered services furnished by an out-of-network provider or emergency facility (regardless of the department of the hospital in which the items and services are furnished) after a member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which emergency services are furnished.
- Air ambulance services provided by an out-of-network provider.
- Nonemergency services provided by an out-of-network provider at an in-network facility if the nonemergency services involve otherwise covered surgical or ancillary services, or other covered services provided by an out-of-network provider.

For the services above, members are responsible for in-network copayments, coinsurance and deductibles which will be applied to in-network maximum out-of-pocket amounts.

Provider remits should indicate whether a particular service is protected from balance billing and indicate how a provider may initiate disputes over reimbursement amounts for these services.

Commercial - Additional Provider Responsibilities Under "No Surprises Act" Regulations

In addition to prohibitions against balance billing listed above, Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act) includes the following requirements for providers and facilities:

- Provision of good faith estimate in advance of scheduled services, or upon request (PHSA 2799B-6; 45 CFR 149.610) (for uninsured or self-pay individuals). The estimate must include expected charges for the items or services that are reasonable to be expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities.
- Ensure continuity of care when a provider's network status changes.
- A provider or facility must disclose to any participant, beneficiary, or enrollee in a group health plan or group or individual health insurance coverage to whom the provider or facility furnishes items and services information regarding federal and state (if applicable) balance billing protections and how to report violations. Providers or facilities must post this information prominently at the location of the facility, post it on a public website (if applicable) and provide it to the participant, beneficiary, or enrollee in a time frame and manner outlined

in regulation.

- Must submit provider directory information to a plan or issuer that includes, at a minimum:
  - At the beginning of the network agreement with a plan or issuer
  - At the time of termination of a network agreement with a plan or issuer
  - When there are material changes to the content of the provider directory information of the provider or facility
  - Upon request by the plan or issuer
  - At any other time determined appropriate by the provider, facility, or HHS

Providers will reimburse members who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost sharing amount.

Hold Harmless Policy

For all Sentara Health Plans products, if Sentara Health Plans denies a claim for service due to failure of the contracted providers to follow any rule or procedure or based on retrospective review that the service was not medically necessary, the provider must hold the member harmless and not bill the member.

Appropriate Service and Coverage

Sentara Health Plans has mechanisms in place to detect and correct potential under and overutilization of services. As such:

- Utilization management (UM) decision-making is based only on appropriateness of care and service.
- The managed care organization does not compensate providers or other individuals conducting utilization review for denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage denials of coverage or service.

Medical Necessity

For commercial plans, Sentara Health Plans uses Sentara Health Plans Medical Coverage Policies and MCG (formerly known as Milliman Care Guidelines) in making medical necessity determinations. Coverage decisions are based upon medical necessity. For Medicare, Sentara Health Plans uses Medicare Manuals, National or Local Coverage Determinations, criteria within MCG (formerly known as Milliman Care Guidelines), and Sentara Health Plans Medical Coverage Policies in making medical necessity determinations.

Sentara Health Plans may deny claims for services deemed medically unnecessary. For commercial plans, if the provider does not agree with Sentara Health Plans' determination, the provider may submit medical documentation (chart copies, treatment sheets, consultation reports, etc.) with a request for reconsideration to Sentara Health Plans.

Members may not be billed for services determined to be not medically necessary by Sentara Health Plans, unless:

- The member has been informed prior to receiving the services that those services may not be covered under the member's benefit plan.
- The members have agreed in writing to pay for the services at the time or before services are rendered.
- A patient should be billed directly if it cannot be proven that a patient is a member at the time of service. If it is later determined that the patient is indeed a member, you must refund the member any payments he/she made more than applicable copayments, coinsurance, or deductibles and file a claim for the service rendered.

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.

Corrected Claim Submission of a Previously Billed Claim

UB-04 Claims

- Bill type is a key indicator to determine whether a claim has been previously submitted and processed.
- The first digit of the bill type indicates the type of facility.
- The second digit indicates the type of care provided.
- The third digit indicates the frequency of the bill.
- Billing type is important for interim billing or a replacement/resubmission bill.
- "Resubmission" should be indicated in block 80 or any other unoccupied block of the UB-04.

CMS-1500 Claims

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

Inpatient Billing Information

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

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

Inpatient claim coding must follow "most current" coding based on the date of discharge. If codes become effective on a date after the member's admission date but before the member's discharge date, Sentara Health Plans recognizes, and processes claims with codes that were valid on the member's date of discharge. If the Hospital Agreement terms change during the member's inpatient stay, payment is based on the Hospital Agreement in effect at the date of discharge. If the member's benefits change during an inpatient stay, payment is based upon the benefit in effect on the date of discharge. If a member's coverage ends during the stay, coverage ends on the date of discharge.

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

Pre-Admission Testing

Pre-admission testing may occur up to ten (10) days prior to the ambulatory surgery or inpatient stay. The testing may include chest X-rays, EKG, urinalysis, CBC, etc. The tests should be performed at the same facility at which the ambulatory surgery or inpatient stay is ordered. The tests should be billed on the inpatient or ambulatory surgery claim. The admission date for ambulatory surgery must be the actual date of surgery and not the date of the pre-admission testing.

Sentara Health Plans will only pay separately for pre-admission testing if the surgery/ confinement is postponed or canceled. If the pre-admission testing is billed separately from the ambulatory surgery or inpatient stay and the surgery was not postponed or canceled, the pre-admission testing will be denied "Provider billing error, provider responsible" (D95).

Readmissions

Members readmitted to the hospital for the same or similar diagnosis will be considered as one admission for billing and payment purposes according to the terms of the Facility Agreement. This protects the members from having to pay multiple cost-share amounts for related readmissions within a short period of time.

Never Events and Provider-Preventable Conditions

Sentara Health Plans requires providers to code claims consistent with CMS "Present on Admission" guidelines and follows CMS "Never Events" guidelines.

A "never event" is a clearly identifiable, serious, and preventable adverse event that affects the safety or medical condition of a member and includes provider-preventable conditions. Healthcare services furnished by the hospital that result in the occurrence and/or from the occurrence of a "never event" are considered noncovered services.

When an inpatient claim is denied as a "never event," all provider claims associated with that "never event" will be denied. In accordance with CMS guidelines, any provider in the operating room when the error occurs who could bill individually for their services is not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. The hospital providing the repair will be paid. All "never event" claims are reviewed by the Sentara Health Plans medical director.

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.

Newborn Claims (Commercial)

Claims for newborn members may be sent utilizing the subscriber's member ID number, the newborn's date of birth, and the newborn's name in field two of the CMS-1500 form. Coverage for a newborn child or adopted newborn child of a member will begin at birth if the newborn is added to the plan within 31 days of birth. Sentara Health Plans does not delineate between sick or well newborns or whether the care is rendered in an inpatient facility or provider's office. Claims for infants outside of 31 days from the newborn's date of birth will be suspended for review of newborn eligibility and will be processed according to the enrollment status of the newborn.

Normal newborn charges for care rendered in the hospital (while the mother is confined) will be paid whether the newborn is enrolled in Sentara Health Plans or not. One claim should be submitted for the mother and a second claim should be submitted for the newborn.

If the newborn must stay in the hospital after the mother has been discharged (boarder baby), the newborn must be enrolled and must have an inpatient prior authorization under the newborn's own member ID number for the charges to be covered. The "boarder baby's" date of admission should equal the mother's date of discharge.

Please see the Sentara Health Plans Medicaid Program Care Provider Manual for newborn enrollment information.

Organ Transplants

Sentara Health Plans contracts directly with Optum Health Care Solutions for organ transplantation services. A limited number of direct contracts with local and regional transplant providers are used as part of the Optum Managed Transplant Program. Prior authorization is required for transplant services, even if Sentara Health Plans is the secondary payer.

Prior authorization should be obtained at the time the member is identified and referred for organ transplant evaluation for all plans.

Please see the Sentara Health Plans Medicaid Program Provider Manual for transplant information specific to the Medicaid program.

Skilled Nursing Facility Services

Placement in a Skilled Nursing Facility (SNF) requires prior authorization. Clinical Care Services nurses work with hospital and nursing facility staff to

assist in making the necessary arrangements for the Skilled Nursing Facility admission. Utilization Review (UR) Nurses review SNF services concurrently and review the facility continued stay for medical necessity in collaboration with Plan Medical Directors. UR Nurses will assist in the member's transition to home or to a lower level of care. Skilled Nursing Facility benefits are limited and vary by plan. If the member exhausts their SNF benefit limit, continued stay requests are not covered. Custodial care is not a Covered Benefit.

For more regarding SNF Medicare guidelines, please reference Chapter 8 of the Medicare Benefit Policy Manual.

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 "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 problems (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)".

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 having responsibility for the charges.

Facility Outpatient Services

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

Outpatient facility services typically have a member cost share associated with them. Sentara Health Plans assigns certain revenue codes to specific plan benefits. For example, revenue codes 0450-0459 are mapped to Emergency Department services and further drive the determination of the member's cost share. The default outpatient benefit is "outpatient diagnostic". Member cost share may be waived if the member is subsequently admitted.

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

Laboratory Services

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

Emergency Department Services

Emergency services are those healthcare services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual
- Danger of serious impairment of the individual's

bodily functions

- Serious dysfunction of any of the individual's bodily functions
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Examples of emergency services include but are not limited to, heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, other acute conditions, mobile crisis services, or other behavioral health conditions.

There are no follow-up days associated with an emergency room visit. Emergency room providers must direct the member to the appropriate provider for follow-up care.

A member liability amount may apply under the member's benefit plan. If the member is directly admitted to the same hospital where the ER service was performed, the emergency room facility charges should be added to the inpatient or ambulatory surgery bill submitted by the facility. The member is only responsible for the inpatient or ASC copayment, coinsurance, or deductible, as applicable. If the member is not directly admitted to the same hospital, the Emergency Department charges are paid separately from the inpatient charges. In this situation, the member may visit the Emergency Department, return home, and be admitted later in the day (normally within 24 hours).

Member Cost Share

You should expect payment of member copayments at the time of service. If the copayment is more than the charges for the service rendered, the allowed charge amount should be billed to the member instead of the full copayment.

The Sentara Health Plans remittance advice will indicate the "patient responsibility" amount. After receipt of the remittance, you will be able to calculate and bill the member for the amount due for any coinsurance or deductible.

Coordination of Benefits (COB)

Group health plans coordinate benefits with various other payers on either a primary or secondary basis to avoid duplication of coverage among payers that have partial liability for the same bill. Work-related claims and similar liability insurance claims are not covered by group health plans.

Access detailed Sentara Health Plans Coordination of Benefits Policies found **here**.

For Dual-Eligible Members with both Medicare and Medicaid, Sentara Health Plans will coordinate the claim processing for primary and secondary, therefore no secondary claim submission is required for payment. This applies to all Dual-Eligible members, regardless of whether the member has Sentara Health Plans for Medicare or Medicare fee-for-service.

Dual-Eligible Members with Both Medicare and Medicaid

If services are provided to a member who is eligible for both Medicare and Medicaid, then the provider may not bill or hold liable the dual-eligible member for Medicare Parts A and B cost sharing if Medicaid is liable for such cost sharing. The provider may either accept the Medicare plan payment as payment in full, or may bill the appropriate state agency. Sentara Health Plans will coordinate the claim processing for primary and secondary, therefore no secondary claim submission is required for payment. This applies to all Dual-Eligible members, regardless of whether the member has Sentara Health Plans for Medicare or Medicare fee-for-service.

Services Being Billed	Primary Insurance	Billing Instructions
Medicaid Program Waiver Only (Medicare Non-Covered Services)	Sentara Health Plans D-SNP Medicare FFS Other TPL Coverage	Bill directly to Sentara Health Plans.
	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.
All Other Services	Other TPL Coverage	Bill directly to the primary insurance. Upon receiving the final determination (Remit/EOB) from the primary payer, submit a secondary claim to Sentara Health Plans.
	Medicare FFS	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.

Pursue Letter

On occasion, Sentara Health Plans may be identified as the member's primary insurance in error. If Sentara Health Plans has paid as the primary carrier instead of the secondary carrier, Sentara Health Plans will send a "pursue" letter to the provider stating the member has other primary insurance. If the provider has not received the EOB from the primary carrier after 30 days of receipt of Sentara Health Plans pursue letter, Sentara Health Plans will retract any claim paid and deny the claim pending receipt of the primary carrier's EOB.

If the provider files with the primary insurer, Sentara Health Plans will coordinate as the secondary carrier.

Overpayments

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 Integrity Manual.

In most cases, when a provider is paid in error, 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 receivables address in the "Sentara Health Plans Key Contacts" 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 receivables address. Please be sure to make the check payable to the company that sent you the check.

Claims

General Information and Filing Requirements - Rendering and/or Billing Provider

- The preferred method for claim submission to Sentara Health Plans is electronic claim submission. Claims can be submitted through Availity or any clearinghouse that can connect through Availity.
- All claims must be submitted within the guidelines of the product (see the "timely filing" section in this chapter), or they will be denied as a late claim submission.
- Claims submitted must be for participating providers
- Submit paper claims on the standard CMS-1500 form for professional providers or UB-04 form for facilities.
- All claims must be "clean claims."
- To process a claim, Sentara Health Plans requires a valid W-9 for the provider tax identification number (TIN) on file with Sentara Health Plans. Claims submitted without a W-9 may be administratively denied by Sentara Health Plans. Sentara Health Plans may require that any claim submitted without a valid W-9 on file be resubmitted to be processed.

NPI

All claims submitted to Sentara Health Plans must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number and taxonomy code will be rejected or denied.

Completing the CMS-1500 Claim Form

To expedite payment and avoid resubmission of claims, it is important to fill out the CMS-1500 claim form as completely and accurately as possible. Submit claims containing all the data elements and industry-standard coding conventions. The National Uniform Claims Committee (NUCC) provides standard instructions for completing the CMS-1500 form on their website at **nucc.org**.

The CMS-1500 claim form version 02-12 is required by Sentara Health Plans.

Listed below are some of the fields that cause most payment delays:

- Complete all patient-identifying information in boxes 1–13. The member's ID and group number should be placed in boxes 1a and 11. Paper claims will be accepted when billed under the Sentara Health Plans member ID or the Social Security number.
- The member's name submitted on the claim must match the member's name in box 12.
- Either the patient's signature or the words "signature on file" are required.
- ICD-10 diagnosis codes are required on all claims, or the claim will be denied for an invalid diagnosis code and must be resubmitted for correction within 365 days from the last date of service.
- For unlisted or miscellaneous procedure codes (codes ending in 99), an English description

of services or a complete list of supplies must be provided.

A "clean claim" will generally be processed and paid by Sentara Health Plans within 30 days of its receipt. Processing delays may occur for claims that require coordination of benefits, code review, or medical review.

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

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

Negative Vendor Status

This term is used for information purposes for claims that are paid to vendors with negative balances. Vendors can enter a negative status when retractions are greater than positive payments. Retractions are done to correct overpayments. An example of a common overpayment issue is if Sentara Health Plans paid a claim as the member's primary carrier but should have paid as secondary. Reversing the claim to pay as secondary could create a negative balance if the dollar amount for other claims being paid would not cover the reversal. The provider would then be in a negative vendor status and receive no additional payments until new claims are approved for payment or a refund is received by Sentara Health Plans. Sentara Health Plans will provide written notice to a provider at least 30 days in advance of reversing any claim. Such notice will specify the claim(s) to be reversed and explain why the claim(s) is being reversed.

Interim Reports

When providers enter a negative vendor status, they begin receiving a negative vendor interim statement rather than a check and a remit. The negative vendor interim statement reports all claims received and processed to that vendor's account for that month. It is to be used for information purposes only and should not be used for posting. When enough claims have been received to balance out the negative amount, or the provider refund check has been received, the provider will receive a remit. Claim payments will resume.

Currently, interim reports are only sent to providers that have claims with dates of service prior to January 1, 2024. For dates of service after January 1, 2024, the forwarding balance appears on the Explanation of Payment, and an interim statement would not be produced for the vendor.

Pending Claims

If a claim needs to be reviewed by claims processing or clinical staff, it will be assigned a "suspend" code. The "suspend" code states the reason for the suspension.

If a claim has not been paid or denied and is not pending for any reason, please call provider services for information. If the claim is confirmed as not received, a second request must be submitted. These claims are subject to the timely filing policy.

Timely Filing Policy

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

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

Duplicate Claims and Corrections

Duplicate claim submission is one of the biggest obstacles encountered during the claims process. If you are unsure if a claim has been filed, please view claim status on the Sentara Health Plans provider portal, or call provider services to inquire on the status of your claim. Sentara Health Plans checks for duplicate claims by comparing the member number, vendor identification number, date of service, procedure code, and total charges of the current claim to claims that are stored in the member's history. Some service lines may be paid, and other service lines denied as duplicates, or the entire claim may be denied as a duplicate.

A "new claim" is a first submission by the provider. It has not been previously billed or processed and does not reference another claim.

A 're-billed" or "corrected claim" is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service, and/or procedures.

Registered providers may electronically submit claim corrections through the Sentara Health Plans provider portal. Providers can make changes or corrections online for the following:

- Procedure/Service coding
- Diagnosis
- Billed charges
- Quantity
- Place of service

This option is not available for hospitals and ancillary claims that would typically use the UB-04 format.

Electronic corrections are accepted in an electronic claim file through a clearinghouse or software vendor. Claims sent through a clearinghouse or software vendor must have a seven-frequency code in the CLM05-3 segment of the 2300 loop of the 5010 A1 837 professional guides. If a claim is resubmitted without the resubmit code, the claim will be denied as a duplicate. Contact your software vendor or clearinghouse with questions about how to send this code.

Changes in Insurance Information

If a provider receives corrected insurance information from the member and provides supporting documentation (for example, original dated registration, new registration, etc.) the provider may submit a claim to Sentara Health Plans within 90 days of receipt of the new information.

Retroactive Disenrollment

Sentara Health Plans will use reasonable efforts to determine in a timely manner that a member has been disenrolled. Should an employer group retroactively disenroll one of its members, Sentara Health Plans may retract claim payments for that member made for dates of service falling after the effective date of the member's disenrollment. The provider will be given 30 days' notice prior to the retraction of any claim.

Individual and Family Qualified (QHP) Sold on the Virginia Health Insurance Marketplace 90-Day Grace Period Mandate

Plans sold on the Virginia marketplace have a mandated 90-day grace period for individuals who receive an advance premium tax credit (APTC) when they have paid at least their first month's premium but are delinquent in subsequent premium payments.

In accordance with the mandate, Sentara Health Plans will process claims for service rendered during the first month of the grace period. Claim payment for services received during the second and third month of the grace period will be suspended until the premium is paid in full or the grace period ends, and the member's enrollment is terminated for nonpayment.

If the member fails to pay the full premium balance before the end of the grace period, the member will be disenrolled as of the last day of the first month of the grace period. At that time, all claims for services during the second and third months will be denied, and the member will be responsible for the payment of these services in full. Sentara Health Plans will not retract claim payments from services rendered during the first month of the grace period.

Providers will receive notification when claims are suspended for nonpayment of premium during the second and third months of the grace period and will be informed of a grace period status when contacting provider services for eligibility verification. Eligibility status is also available 24 hours a day through either the Availity or Sentara Health Plans provider portals located **here**.

Claims Denied in Error

The provider's office must follow up with Sentara Health Plans within 365 days of the date of service for claims the provider suspects have been denied in error. If, after researching the claim, Sentara Health Plans discovers that the claim was denied in error, the provider is entitled to payment.

Workers' Compensation

Any claim with an injury diagnosis code for a patient over the age of 16 will be reviewed. Sentara Health Plans communicates with the members to determine if the injury is work-related. We will automatically send a letter to the member requesting information about the injury. The member has 20 days to respond to the request for information.

If a claim is paid under a Sentara Health Plans benefit plan prior to determining that it is a workers' compensation claim, Sentara Health Plans will reverse the payment. The claim should be submitted through the member's employer's workers' compensation plan.

Provider Dispute Resolution

Subject to the exceptions noted below, any dispute initiated by the provider arising out of or relating in any manner to the Provider Agreement, whether sounding in tort, contract, or under statute (a "Provider Dispute") shall first be addressed by exhausting all Policies and Procedures applicable to the Provider Dispute before a provider may seek to resolve the Provider Dispute in any other forum or manner. Policies and Procedures shall include the following: Program Integrity Audit, Reconsideration and Appeals Policy; Provider Appeals Procedure; Credentialing/Recredentialing Appeals Process; and Appeals of an Adverse Benefit Determination Policy. If the Provider Dispute is of a type not subject to the Policies and Procedures, the provider and Sentara Health Plans shall engage in good faith negotiations between their designated representatives (such representatives shall be authorized to resolve the dispute). The provider must initiate negotiations upon written request to SHP (the "Meeting Request Notice") delivered in accordance with the notice requirements in the Provider Agreement within ninety (90) days of the date on which the provider first had, or reasonably should have had, knowledge of the event(s) giving rise to the Provider Dispute. The negotiations shall commence within thirty (30) calendar days after Sentara Health Plans receives the Meeting Request Notice, and the provider may not seek to resolve a Provider Dispute in any other forum or manner unless the Provider Dispute is not resolved within ninety (90) days after Sentara Health Plans' receipt of the Meeting Request Notice. This section shall not apply to, with respect to fully-insured payors, disputes arising as a result of SHP's violation of Va. Code § 38.2-3407.15 or SHP's breach of any provision(s) of this Agreement that is required under Va. Code § 38.2-3407.15. 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.

Electronic Claims and Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT)

EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 24 hours after payments are processed. Clean claims are processed and paid for by Sentara Health Plans within an average of seven days when submitted electronically and when payment is made through EFT. Commercial providers must complete the electronic payment/remittance authorization agreement to enroll.

NOTE: For providers who service multiple product lines, enrollment will be required through Sentara Health Plans and Payspan.

The form for commercial enrollment can be accessed **here**.

For Medicare claims, EFT and ERA will be issued through Payspan. This will require a Payspan account. For providers that already access Payspan, updates will be required.

New Payspan Users – How to Register:

Contact **providersupport@payspan.com** or **1-877-331-7154**, option 1, for help obtaining registration codes and assistance with navigating the website. Provider services specialists are available to assist Monday through Friday from 8 a.m. to 8 p.m.

If provider data is not loaded in Sentara Health Plans' new claims platform, or if feedback is received from Payspan that there is no provider entry in the Payspan system, a claim must be submitted to Sentara Health Plans to receive a paper check. This check will include registration information for Payspan.

For Current Payspan Users:

If providers already have an account, there will be a single registration code that is tied to the pay-to-entry. If there are multiple pay to entries in Sentara Health Plans' claims platform, providers will have multiple registration codes. To obtain a code, providers can contact Payspan and provide their TIN/NPI.

If there are any questions, please contact a Payspan provider service representative at **1-877-331-7154**.

Filing Claims Electronically

Providers that submit claims to Sentara Health Plans' electronic claims program 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 payer ID number is 54154.
-
- Providers who can receive data files in the HIPAA compliant ANSI 835 format may elect to receive EFT/ERA from Sentara Health Plans or Payspan. The 835 transaction contains 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**.

- All claims must be submitted within the timely filing policy provisions stated in your agreement or as dictated by plan policy. Please see the "Timely Filing Policy" section in the "Claims" chapter of this manual.
- Claims submitted electronically will be accepted when billed under the member's Sentara Health Plans member ID. Providers should first review their clearinghouse requirements for submission of member identification to confirm that their clearinghouse will accept claims using their chosen option for submission.
- Claims submitted must have charge amounts. Claims for zero charge amounts will be rejected.
- Claims submitted electronically will be processed within 24 hours of receipt.

Required Claims Information

All information noted in the "Claims" chapter of this manual is applicable to claims filed electronically.

Birth Date

Claims submitted with incorrect birth dates (the birth date submitted does not match the birth date associated with the member ID number submitted) will be denied (in QNXT system) or rejected (in CSC system).

Corrected Claim Submissions

Sentara Health Plans accepts the following corrections electronically:

- Patient payment
- Service periods/dates
- Procedure/Service codes
- Charges
- Units/Visits/Studies/Procedures
- Hospitalization dates
- Name or ID number of the referring provider
- Provider ID
- Wrong member ID number or birth date

Coordination of Benefits Claim Submissions

Sentara Health Plans accepts secondary and subsequent claims electronically. Your clearinghouse or software vendor is the best resource for you to determine how to submit the necessary data. Please provide:

- Full claim allowed amount
- Patient responsibility at the claim level
- Any additional line information that is available

Status Reports

Provider sites receive "status" or "response" reports that will give the total number of claims transmitted and whether they were accepted or rejected.

Support for Electronic Claims Filing

The Sentara Health Plans Professional Companion Guide is available **here**.

The Sentara Health Plans Institutional Companion Guide is available **here**.

Contact your current EDI vendor for:

- Problems with transmission
- Level one or level two errors

Contact provider services for:

- Consistent rejections of claims, although information is correct
- Status of claims received electronically
- Questions concerning the adjudication or payment of claims sent electronically

Infortmation for Specific Claim Types (A-Z)

After-Office Hours Codes

- After-office hours codes can only be billed when the services extend beyond the posted hours.
- Two codes are used for billing after-hours care: the appropriate office visit code and the appropriate after-hours code.
- Specialists are not reimbursed for after-hours codes.

Allergy Claims

The office visit copayment applies to allergy injections. The date of each injection must be indicated on the claim. Since allergy benefits vary, please confirm eligibility and specific allergy benefits and authorization requirements by calling provider services and choosing option 2.

Code 99211

CPT code 99211 is used for an evaluation and management visit that may not require the presence of a physician. Presenting problems are usually minimal, and time spent performing or supervising services is typically five minutes or less. An appropriate use of this code would include a blood pressure check performed by a nurse where medications were maintained or changed at the time of the visit. This service includes an exam and decision making.

Code 99211 should not be used if only the following services are being performed on the date of service:

- Administration of injections (vitamin B-12, Depo-Provera, etc.)
- Administration of medication for an established course of therapy following a protocol that does not require physician input for dosing (chemotherapy, PUVA) when no other services are performed
- Routine in-person prescription renewal and telephone prescription renewal
- Venipuncture (use code 36415 when no other service is performed)
- Allergy injections

Fluoroscopic Guidance and Contrast

Sentara Health Plans allows the reimbursement of fluoroscopic guidance and, in general, follows CCI guidelines on payment of this procedure. The policy is available upon request.

Sentara Health Plan allows the reimbursement of contrast materials under specific circumstances in accordance with CMS guidelines. The policy is available upon request.

Incident-to Guidelines

Per CMS, national coverage provision for incident-to-services, when nonphysician practitioners (NPPs) render services that are incident to a physician services, they may bill under the physician when the service is:

- An integral part of the physician's professional service
- Commonly rendered without charge or included in the physician's bill
- Of the type that is commonly furnished in physician offices or clinics
- Furnished by the physician or auxiliary personnel under the physician's direct supervision

CMS defines incident-to-services as those performed by an NPP who is under the supervision of a physician and who is employed by or contracted with the physician or the legal entity that employs or contracts with the physician.

There must have been a direct, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician is an incidental part, which means that the physician must see the patient first to initiate the plan of care for the patient. The NPP would follow the physician's plan of care for subsequent services. The physician must perform the initial service for the diagnosis and must remain

actively involved during treatment. The physician must perform subsequent services that reflect his or her continued active involvement in the patient's care.

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

Example: If a patient informs the NPP of a new problem while being seen in a subsequent visit for an established problem with an established plan of care, the visit cannot be billed incident-to because the physician has not seen the patient to establish a new plan of care for the new problem. If the NPP is credentialed with Sentara Health Plans and the services are within the NPP's scope of practice, then the NPP should bill the appropriate level of new or established E/M service provided under his or her own provider number.

Per CMS guidelines, "Direct supervision in the office setting means the physician must be present in the office suite and immediately available to provide aid and direction throughout the time the service is performed. Direct supervision does not mean that the physician must be present in the same room with his or her aide."

The only time an NPP can bill a service under a physician is when a physician is in the office suite and directly available to help. The physician being available by phone is not appropriate and does not constitute direct supervision. More information is available from:

CMS. (Revised 2016). Incident-to located **here**.

Behavioral Health Resident in Training & Supervisees

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

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

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

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

Subrogation

Subrogation laws vary by state, and some states' laws do not permit subrogation for certain products. Sentara Health Plans follows the applicable state law.

Claim Payment Reconsiderations

A A reconsideration (sometimes confused with claims corrections) is a written notification from the provider indicating their request to review how a claim is processed. No changes to the claim are being made.

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

Non-participating Medicare providers have 60 days from the last claim adjudication date to file reconsideration and must also submit "Waiver of Liability" agreeing not to balance bill regardless of reconsideration outcome.

Provider Reconsideration Forms are available on the Sentara Health Plans website or by calling provider services. Online forms are as follows:

Provider Reconsideration Form (medical claims)

Behavioral Health Provider Reconsideration Form (behavioral health claims)

Reconsiderations submitted using the CMS-1500 form should indicate the original claim number. All line items submitted on the original claim should be included. Mail the completed Provider Reconsideration Form and, if necessary, any attached documentation to the claim reconsideration address found at the top of the appropriate Provider Reconsideration Form.

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

Late Claim Reconsiderations

Requests for waivers to the timely filing requirements due to an exceptional circumstance must be made in writing within the reconsideration filing deadlines and should be submitted to the Sentara Health Plans claims department.

Submit Reconsideration requests through the following methods:

Electronic

For Medicare, providers can submit reconsideration requests electronically by using Sentara Health Plans' **payertransactions.com**. For providers who have not used the **payertransactions.com** Claim Reconsideration Portal in the past, please register directly by accessing this **link** and select "Need an account".

Mail

For Commercial and Medicare, providers can mail requests to the following addresses:

Medical Claims:
PO Box 8203,
Kingston, NY 12402-8203

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

Fraud, Waste, and Abuse

Sentara Health Plans is responsible for detecting and preventing fraud, waste, and abuse (FWA) in accordance with the Deficit Reduction Act and the False Claims Act. Sentara Health Plans, through the program integrity unit (PIU), has implemented policies and procedures to detect and prevent all forms of insurance fraud, including fraud involving employees, providers, employer groups, and contractors or agents of Sentara Health Plans.

Sentara Health Plans has adopted the Commonwealth of Virginia's definition of fraud, waste, and abuse (FWA) as any "suspicious claims activity," which is any claim that an insurance company has reason to believe, based upon evidence, and may contain one or more material misrepresentations. Sentara Health Plans further defines fraud and abuse as "intentional deception or misrepresentation made by a person or entity with

the knowledge that the deception could result in payment of an unauthorized benefit."

Common types of fraud and/or abuse are as follows:

- Unbundling
- Split billing
- Services not rendered
- Upcoding
- Falsification of records/bills/enrollment applications
- Waiving copayments/deductibles
- Duplicate claims submissions
- Prescription drug switching or shorting
- Dispensing expired or adulterated prescription drugs
- Prescription drug-seeking behavior, theft, forging, or altering of prescriptions
- Identity theft
- Improper COB
- Over/Underutilization

The Sentara Health Plans anti-fraud plan is carried out through the efforts of its PIU. The PIU is an internal investigative unit, separate from the compliance department, whose responsibility it is to:

- Detect and prevent fraud, waste, and abuse
- Ensure correct payment of medical, behavioral health, and prescription services, including correct coding, reimbursement, quantity, and quality
- Utilize real-time systems that ensure accurate eligibility, benefits, and reimbursement
- Reduce or eliminate fraudulent or abusive claims paid
- Identify members abusing medical and prescription services
- Identify and recommend providers for exclusion from the network as a result of fraudulent or abusive practices
- Identify fraud on employer group enrollment applications
- Refer potential FWA cases to the appropriate authorities
- Identify and report illegal activities and assist law enforcement by providing information needed to develop successful prosecutions

Identification of fraud, waste, and abuse is accomplished through:

- Referrals from employees or providers
- Use of detection software with claims data
- Participation in anti-fraud forums with government agencies
- Staying current with national industry FWA trends through networking and education

The PIU department may receive referrals through internal communications from employees, the Sentara Health Plans Fraud, Waste, and Abuse hotline, or the compliance email. The hotline and compliance email are published on Sentara Health Plans' websites on the explanation of benefits and included in the employee training manual and can be completely confidential.

If you or someone you know has knowledge of a health insurance claim submitted to Sentara Health Plans that may meet the above definition of a "suspicious claims activity," or suspects any provider, enrollee, or employee of Sentara Health Plans may be committing fraudulent or abusive practices, please forward all the pertinent information to the Sentara Health Plans PIU for further investigation. Your complaint will be investigated, and a thorough follow-up will be undertaken, including possible follow-up with you if additional questions arise. All referrals made to the PIU may remain anonymous. Please be sure to leave your name and number if you wish to be contacted for follow-up. If appropriate, the necessary governmental agency (CMS, OIG, BOI, etc.) will be notified, as required by law.

Upon conclusion of the investigation, Sentara Health Plans will pursue restitution for financial loss where appropriate.

In cases of waste and abuse, provider education may be provided to prevent further incidents. If needed, in addition to repayment of any overpayment, a corrective action plan may be issued to a provider that will require them to sign and agree to a plan to correct any issues identified within a specified time.

In cases of fraud, waste, and abuse that go uncorrected after education, Sentara Health Plans reserves the right to terminate a provider, broker, or employer group contract. These cases will be brought to the compliance fraud, waste, and abuse subcommittee for review. This committee is headed by the PIU and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting, and network management.

When a determination of fraud or abuse is made, the case will be reported to the appropriate government agencies, law enforcement, and/or regulatory agency (State Medical Board, State Police, Attorney General's Office, Office of Personnel Management OPM/OIG, MFCU, CMS, FBI, etc.).

All referrals, cases, and supporting documentation are tracked and stored electronically. Supporting documentation may include medical records, letters received and mailed, claims identified, phone call summaries, etc.

Sentara Health Plans encourages providers and requires all provider staff to complete fraud, waste, and abuse training within 30 days of hire and annually thereafter.

Fraud, Waste, and Abuse Training

Access Fraud, Waste, and Abuse Training for providers and office staff **here**.

Federal False Claims Act

The federal False Claims Act's primary use is to combat fraud and abuse in government healthcare programs. The Act accomplishes this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $12,537 to $25,076 per false claim.

The False Claims Act prohibits, among other things:

- Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid
- Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information, 2) acts in deliberate ignorance of the truth or falsity of the information, or 3) and acts in reckless disregard of the truth or falsity of the information.

The False Claims Act also contains a qui tam or "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the applicable state or federal government. The qui tam provision also protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment because of the employee's lawful acts in furtherance of a false claims action.

Providers contracted with Sentara Health Plans I agree to be bound by and comply with all state and federal laws and regulations. Any violation of law by a provider is grounds for termination of their network participation.

Providers contracted with Sentara Health Plans will also comply as follows:

- Provider agrees to comply with all nondiscrimination requirements set forth in the contract.
- Provider agrees to provide access to its premises and to its contracts and/or medical records, to representatives of Sentara Health Plans, as well as duly authorized agents or representatives of the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, and the State Medicaid Fraud Unit in accordance with their contract.

- Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with applicable law.
- Provider agrees to ensure confidentiality of family planning services in accordance with the applicable law.

Program Integrity Audit, Reconsiderations, and Appeals Policy and Procedures

As a managed care organization, Sentara Health Plans is required by state and federal entities to audit claims, identify overpayments, and educate all types of providers on program integrity issues.

Sentara Health Plans conducts claim audits either on a pre-payment or post-payment basis. Claim audits are conducted to confirm that healthcare services and supplies were delivered in compliance with the member's plan of treatment and/or to confirm that charges were accurately reported in compliance with Sentara Health Plans' policies and procedures, as well as general industry standard guidelines and state and federal regulations.

In addition, Sentara Health Plans continually monitors provider billing practices and conducts investigations for purposes of detecting inappropriate, inaccurate, or abusive billing patterns, medical necessity, as well as patient safety and quality of care. Data on provider services for specified periods are compiled and compared with other providers within the same specialty/provider type and geographic peer groups. Providers are selected for audit based on their utilization and billing patterns, relative to their peers.

Providers who are an outlier may be subject to further analysis, including desk or on-site investigations. Investigations will include a review of the provider's medical records that pertain to the billed services and may employ offset of overpayments or extrapolation methods.

Sentara Health Plans has a detailed written policy for the program integrity audit process, including reconsiderations and appeals of audit findings. This policy contains definitions of the terms used, time frames for record request responses, procedures for desk audits and on-site audits, time frames for findings letters to be sent, and time frames for providers to request reconsideration of findings and request an appeal. The policy also includes the Sentara Health Plans medical record documentation standards to which providers are required to adhere.

The complete policy can be found **here**.

Physician Query Requirements

A coding query is defined as "a written question, posed by a coder requesting clarification on documentation in the medical record, which requires further specificity for accurate coding."

Sentara Health Plans will accept appropriate, timely, and compliant physician coding queries submitted as part of the patient medical record to the extent it provides clarification and is consistent with other medical record documentation. Physician queries are not accepted after an audit has been initiated. Sentara Health Plans follows CMS's position on query forms, as stated by the director of CMS's quality improvement group.

Additionally, Sentara Health Plans will not accept the practice of assumptive coding and will refer for further action any facility found to be practicing assumptive coding. The Office of Inspector General (OIG) defines assumptive coding as "assuming (and coding) from the clinical evidence on the patient's record that the patient has certain diagnoses in the absence of the physician's explicit documentation of the diagnosis." Assumptive coding is a forbidden practice among coders.

Sentara Health Plans will evaluate coding queries as follows:

Clarity and Language:

The physician query process involves asking a physician to clarify inconsistent, vague, or otherwise unclear documentation about a patient's diagnosis. The physician query process should only be triggered when there is a problem with documentation quality and there are clinical triggers that act as "clues" to guide the coder in the query process.

Coders' queries to physicians should:

- Be initiated only when there is sufficient supporting documentation within the body of the medical record to warrant a query
- Present or refer to specific clinical information within the record that prompted the query
- Be clear, open-ended questions allowing the physician to render and document his/her clinical interpretation of the diagnosis, condition, and/or procedure, based on the facts of the case
- Indicate why the query is required (principal diagnosis is unclear, conflicting documentation, etc.)

Queries which are leading in nature, refer to differences in payment, and/or introduce new information will not be accepted for DRG validation by Sentara Health Plans and may be subject to referral for further action.

Examples as to when a physician query is appropriate:

- Documentation regarding reportable conditions
- or procedures is conflicting, ambiguous, or is otherwise incomplete.
- Abnormal diagnostic test results indicate the possible addition of a secondary diagnosis or higher specificity of an already documented condition.
- The patient is receiving treatment for a condition that has not been documented.
- Abnormal operative/procedural findings are not documented.
- It is unclear as to whether a condition was ruled out.
- The principal diagnosis (the reason, after study, for admission) is not clearly identified.

Examples of when a physician should not be queried include:

- There is no clinical indication to warrant a query.
- There is a discrepancy between the physician's diagnosis and clinical indicators. (Unless hospital policy requires a query in this circumstance, policy must be submitted).

Legibility:

Illegible documentation cannot be assumed or interpreted and may be a reason to deny payment for services.

Completeness:

Queries must be maintained as part of the medical record and are subject to the same contemporaneous, permanent, professional treatment of records as the body of the medical record.

Timeliness:

Queries must be submitted to the physician and returned by the physician prior to billing and submitting a UB-04 to Sentara Health Plans. Queries that are not timely will not be accepted for reimbursement or for DRG validation purposes.

Authentication:

Physicians must date and sign all query responses. Physicians also need to date and cosign queries documented by other clinicians whose work they are responsible for. This applies, for example, to residents and interns in teaching facilities.

Physician Self-Treating

Per the American Medical Association (AMA), "professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered." Physicians' professional relationships with their patients are based on fiduciary responsibility. Family relationships and collegial relationships with same-practice physicians, by contrast, are based on familiarity.

As such, Sentara Health Plans will not reimburse any services rendered by a physician to:

- Self
- Family member

DEFINITIONS

The following definitions are important for

understanding this policy:

Family Member: For this policy, "family member" means a physician's spouse or partner, parent, child, sibling, grandparent, or grandchild; a parent, child, sibling, grandparent, or grandchild of the physician's spouse or partner; or another individual in relation to whom the physician has personal or emotional involvement that may render the physician unable to exercise objective professional judgment in reaching diagnostic or therapeutic decisions.

Treating: "Treating" encompasses the performance of any controlled act, including ordering and performing tests, making and communicating a diagnosis, and prescribing medications.

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.

Disclosure of Ownership 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.

Subcontractor, Vendor, and Agent Compliance Program

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

Confidentiality

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

Business Information

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

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

Equal Opportunity Employment

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

Conflict of Interest

Sentara Health Plans employees may not accept:

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

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

Anti-Kickback Act

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

Business Records

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

Billing Practices

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

False Claims

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

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

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

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

Fraud and Abuse

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

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

Any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than $5,000 for each claim and an assessment of not more than twice the amount of the claim.

Sentara Health Plans will investigate all potential fraud and abuse violations and will initiate actions to resolve the identified problem.

Whistleblowers

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

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

Insider Trading

Agents and vendors who have material nonpublic ("insider") information obtained through a

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

Government Sanctioning

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

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

Maintaining Your Position of Trust

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

Virginia Ethics and Fairness in Carrier Business Practices

Below is the text of Virginia Code § 38.2-3407.15, Ethics and fairness in carrier business practices effective as of July 1, 2024. This law applies only to commercial plans.

A. As used in this section:

"Carrier," "enrollee," and "provider" shall have the meanings set forth in § **38.2-3407.10**; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ **38.2-5800** et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator, or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim that does all of the following:

1. Identifies the provider that provided the service with industry-standard identification criteria, including billing and rendering provider names, identification numbers, and addresses;
2. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient was an enrollee at the time of service;
3. 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;

4. Specifies the date and place of service;

5. 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

6. 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.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection K, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, notify the person submitting the claim of any defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the information that will be required to process and pay the claim. Upon receipt of the additional information necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services

rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Beginning no later than January 1, 2026, all notifications and information required under this subdivision shall be delivered electronically.

3. Any interest owing or accruing on a claim under § **38.2-3407.1** or **38.2-4306.1**, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, down coding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or down codes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and down coding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and down coding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. No carrier shall impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), a provider and a carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously paid claim.

Beginning no later than January 1, 2026, all written communications, explanations, notifications, and related provider responses applicable to this subdivision shall be delivered electronically. The electronic method and location for delivery shall be agreed upon by the carrier and provider and included in the provider contract.

8. No provider contract shall fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier's provision of a policy required to be provided under subdivision 9 8 or 10 9 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers. If a carrier's claim denial is overturned following completion of a dispute review, the carrier shall, on the day the decision to overturn is made, consider the claims impacted by such decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the payments due.

12. Every carrier shall include in its provider contracts a provision that prohibits a provider from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a

motor vehicle accident. Nothing in this subdivision shall require a health care provider to treat an enrollee who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

13. Beginning July 1, 2025, every carrier shall make available through electronic means a way for providers to determine whether an enrollee is covered by a health plan that is subject to the Commission's jurisdiction.

C. A provider shall not file a complaint with the Commission for failure to pay claims in accordance with subdivision B 1 unless:

1. Such provider has made a reasonable effort to confer with the carrier in order to resolve the issues related to all claims that are under dispute. Any request to confer shall be made to the contact listed for such purpose in the provider contract and shall include supporting documentation sufficient for the carrier to identify the claims in question; and

2. At least 30 calendar days have passed from the date of the request provided that the carrier has been responsive to the providers request to confer. However, if in the judgment of the provider, the carrier has not been responsive to such request, the provider shall not be required to wait at least 30 calendar days to file the complaint.

The provider shall attest in any such complaint that it has satisfied the provisions of this subsection.

D. If the Commission has cause to believe that any provider has engaged in a pattern of potential violations of subdivision B 12, with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in questions were not violations. If any provider has engaged in a pattern of potential violations of subdivision B12, with no corrective action, the Board of Medicine or the Commissioner of Health may levy a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of the review, including where the violation was substantiated, and any enforcement action taken as a result of a finding of a substantiated violation.

E. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

F. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

G. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of

this subsection.

H. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

I. Except where otherwise provided in this section, beginning no later than July 1, 2025, carriers shall deliver provider contracts, related amendments, and notices exclusively to providers in an electronic format other than electronic facsimile. Beginning no later than January 1, 2026, the provider shall submit provider contracts, amendments, and notices to carriers exclusively in an electronic format other than electronic facsimile. The electronic method and location for delivery shall be agreed upon by the carrier and provider and included in the provider contract.

J. This section shall apply only to carriers subject to regulation under this title and shall apply to the carrier and provider, regardless of any vendors, subcontractors, or other entities that have been contracted by the carrier or the provider to perform duties applicable to this section.

K. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

L. Pursuant to the authority granted by § **38.2-223**, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

M. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.