Sentara®
Health Plans

Medicaid Provider Desk Reference

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(this document is interactive)

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Purpose of the Guide

The Sentara Health Plans Medicaid Provider Desk Reference provides an overview of the Sentara Health Plans Medicaid program. Providers are also encouraged to review **Doing Business With Sentara Health Plans** to learn best practices for conducting business with us successfully. The Medicaid Provider Desk Reference is designed for general information purposes only, and providers should always refer to the Sentara Health Plans Provider Manuals and the provider agreement for the most detailed and up to date requirements.

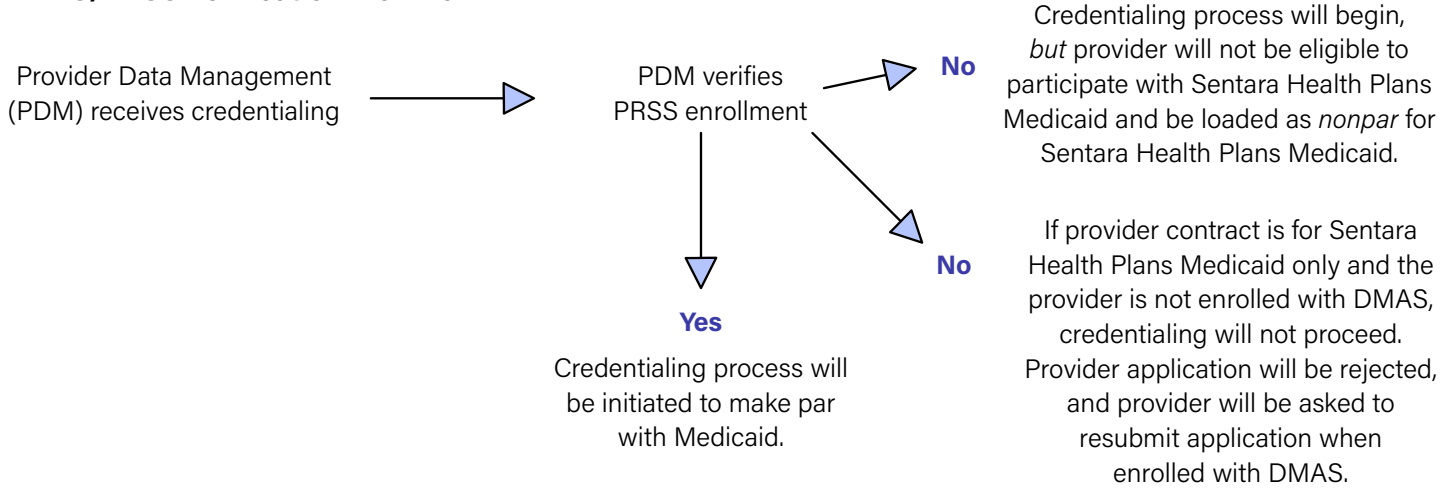
Provider Services Solution (PRSS) Enrollment Requirement

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

Key Points:

- How to Enroll: From **virginia.hppcloud.com/**, go to Menu, then Provider Enrollment, and select either New Enrollment or Enrollment Status.
- Only one enrollment application is necessary in PRSS, even if you participate with more than one managed care organization (MCO).
- All new MCO-only providers must first enroll with PRSS prior to requesting credentialing with one or more of the managed care health plans.

DMAS/PRSS Verification Workflow



Member 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 specific Member Rights and Responsibilities and members are mailed information on where to locate their Rights and Responsibilities at the time of enrollment. Sentara Health Plans Medicaid product members Member Rights and Responsibilities can be found in the **Sentara Health Plans Medicaid Provider Manual**, page 61.

Health Plan Obligations

Sentara Health Plans obligations are in your provider agreement.

Member Eligibility

Always check member eligibility prior to providing services. This is an important step to ensuring reimbursement. Verification may be obtained through our secure portal, or by calling provider services: **1-800-229-8822**. Sentara Health Plans members will be identified as Sentara Community Plan.

Use the MediCall telephonic system and 270-271 eligibility transactions to verify member eligibility and managed care enrollment. Automated response system (ARS) and MediCall will provide the name of the MCO the member is enrolled in and the plan's contact number.

To learn more, visit the Department of Medical Assistance Services (DMAS) **website** at: **dmas.virginia.gov/for-providers/cardinal-care/.**

Identifying a Member

Member ID cards will bear the Cardinal Care logo:

Sentara Health Plans

SENTARA COMMUNITY PLAN

Member Name: JOHN DOE
Member Number: 9999999
Group Number: SCP
Medicaid/Rx ID: 999999999999
PCP Name: JANE DOE
PCP Phone: 123-456-7899
Member Effective Date: 01/01/24

RxBIN: 003858
RxPCN: MA
RxGRP: SHPMDCD

CardinalCare Virginia's Medicaid Program

*Detailed plan information at sentarahealthplans.com

FAMIS

Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

Member Services: *(Hearing Impaired/Virginia Relay: 711)*	1-800-881-2166
Behavioral Health/ARTS Crisis Line:	1-833-686-1595
Transportation:	1-877-892-3986
24/7 Nurse Advice Line:	1-833-933-0487
Pharmacist Help Desk:	1-844-604-9165
Dental:	1-888-912-3456

Medical Claims
PO Box 8203
Kingston, NY 12402

Behavioral Health Claims
PO Box 8204
Kingson, NY 12402

Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466

Sentara Health Plans

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Medical Claims
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Kingston, NY 12402

Behavioral Health Claims
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Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466

Benefits

Standard Covered Services

- doctor, hospital, and emergency services, including primary and specialty care
- prescription drugs
- laboratory and X-ray services
- maternity and newborn care
- home health services
- family planning services
- doula services
- brain injury services

Enhanced Benefits

- 90-minute classes on health-related subjects
- eye exam and $100 for frames annually
- baby showers (in person and virtual)
- free smart phone with 350 minutes, unlimited texts, and free monthly calls to health plan and hotspot
- up to $75 college application assistance
- pre-diabetic health coaching and weight loss program
- 400 diapers per pregnancy (conditions apply)
- up to $20 toward feminine hygiene products
- financial wellness program
- up to $275 toward GED testing voucher
- healthy member incentives (e.g., prenatal/postpartum, childhood immunizations, dental visits, COVID-19, and more)
- free breastfeeding classes, breast pump, etc.
- up to $2,000 toward one hearing aid, exam and fitting annually
- 56 home delivered meals after hospital stay
- $30 per quarter for incontinence products
- one mattress and pillowcase cover for asthmatic members every two years
- memory alarms and other monitoring devices
- $75 savings grocery card toward purchase of healthy foods for pregnant moms
- online community resource guide
- free pedometers
- encourage child reading through Puppet Program
- sports physicals
- 24-hour access for health questions/medical needs, including prescriptions
- 24 round trips per year for nonmedical services
- online education and coaching portal to support well-being needs
- weight management programs
- smoking cessation programs
- iPad or tablet cover (this is only the cover, not the iPad or tablet)
- HEAL program/adult literacy
- baby monitor, sleep sack, or pack-n-play
- 24 round trips per year for LTSS caregivers (non-medical)

Vendor-facilitated Services

- **ASHN:** American Specialty Health Network; Chiropractor Network: claims are paid through ASHN; commercial and Medicare only; **1-800-848-3555**
- **DentaQuest:** Only the Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) (H4499-001) members
- **Delta Dental:** members for all other plans.
- **Modivcare:** transportation vendor; Medicare, and Medicaid
- **MDLIVE:** virtual visits; commercial, Medicare, and Medicaid
- **Nations Hearing:** discounted services for Medicare and Medicaid members
- **Vision Services Plan (VSP):** routine vision care only; commercial and Medicaid
- **Quest Diagnostics:** commercial, Medicare, and Medicaid

Transportation Benefit

Modivcare administers the nonemergency transportation benefit for Sentara Community Plan, Sentara Medicare members, and LTSS caregivers.

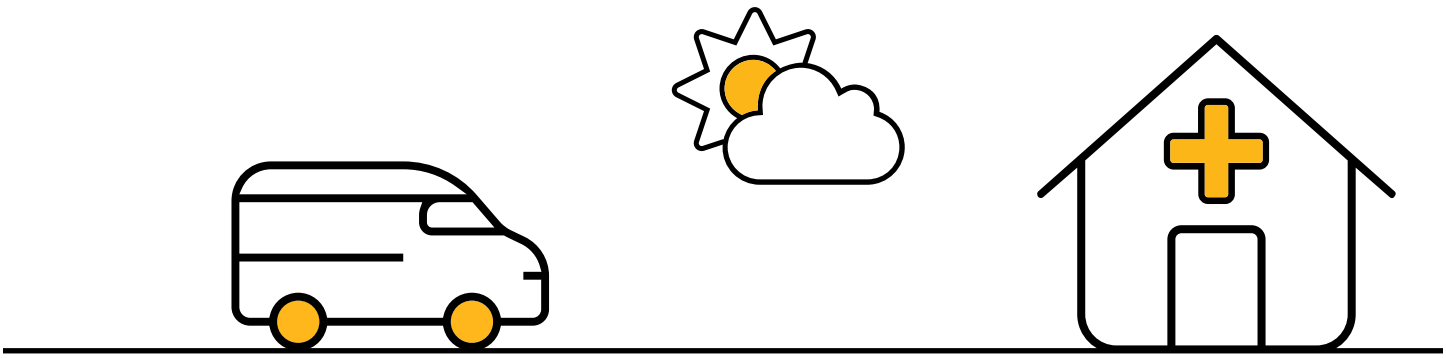
For complete details about the transportation benefit and how it is administered by Sentara Health Plans, you may download the **Nonemergency Transportation Benefit** resource on the Sentara Health Plans' website.

Hours of Operation:

- Monday–Friday, 6:00 a.m.–6:00 p.m.
- urgent trips available on weekends and on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas
- urgent reservations available 24 hours daily
- "Where's My Ride" available 24 hours daily
- routine reservations are available for members and providers scheduling appointments for weekdays after 5 p.m. and on the weekend

Hospital Admission/Emergency Room Visits

Members may be transported from home to hospital **only if being admitted.** Members needing to go to the emergency room must call 911. Emergency ambulance services are not included in the transportation benefit.



Scheduling a Trip

- Members can book online or call to schedule reservations and "will call" return trips:
  - using the member app at **mymodivcare.com/modivcare-app**
  - Sentara Community Plan (Medicaid) members call **1-877-892-3986**
  - Sentara Medicare members call **1-866-381-4860**
  - LTSS caregivers, coordinated through member onboarding/outreach call **1-833-261-2367**
- Facilities may schedule using the facility portal by visiting **tripcare.modivcare.com/login** and setting up an account.
- Recurring Trips: The treating facility's office must submit a written request on behalf of the member for all "Standing Order" trips (regular weekly/daily transportation to a facility or appointment–typically, behavioral health, adult day care, dialysis, and chemotherapy-related appointments).
- All trips must be booked at least three business days (for Sentara Medicare) or five business days (for Sentara Community Plan) in advance of the appointment, unless it is an urgent trip, which will be verified. Trips may be booked up to 30 days in advance.
- For all "Standing Order" trips (regular weekly/daily transportation to a facility or appointment), the provider's office or case manager must submit a written request on behalf of the member. These are typically behavioral health, adult day care, dialysis, and chemotherapy-related appointments.

Mileage Reimbursement

Members can utilize mileage reimbursement in the Modivcare App to schedule trips and request payment for the most efficient mileage reimbursement: **mymodivcare.com/modivcare-app**.

Members must request mileage reimbursement at the time of scheduling the reservation, which can be scheduled up to the same day. Modivcare uses the IRS medical reimbursement rate that is regulated through the IRS to determine mileage. A provider office signature is required.

Standing Orders

The preferred method for facilities to access Standing Orders or Standing Order Change Forms is via the TripCare website at **tripcare.modivcare.com/login** at least three days (for Sentara Medicare) or five days (for Sentara Community Plan) prior to the first date of transport.

- If unable to use TripCare, fax the form to **1-866-907-1497** at least three days (for Sentara Medicare) or five days (for Sentara Community Plan) prior to the first date of transport.
- Call **1-877-892-3986** (Sentara Community Plan) or **1-866-381-4860** (Sentara Medicare) to schedule individual trips if the member needs transport before the standing order goes into effect.
- Allow 24 hours after the form is sent to confirm receipt.
- Fill out forms completely and legibly.
- Print and sign your name.

Information Required for Standing Orders

- Does member require hand-to-hand, door-to-door, or curb-to-curb?
- Does member require wheelchair assistance or other special instructions (such as bariatric, seizure precautions, behaviors, etc.)?
- Information on the type of wheelchair, number of steps, height, and weight.
- Does member have special language and/or other communication requirements?

Doula Services Benefit

For complete information, you may download the Doula Program Guide from the provider website.

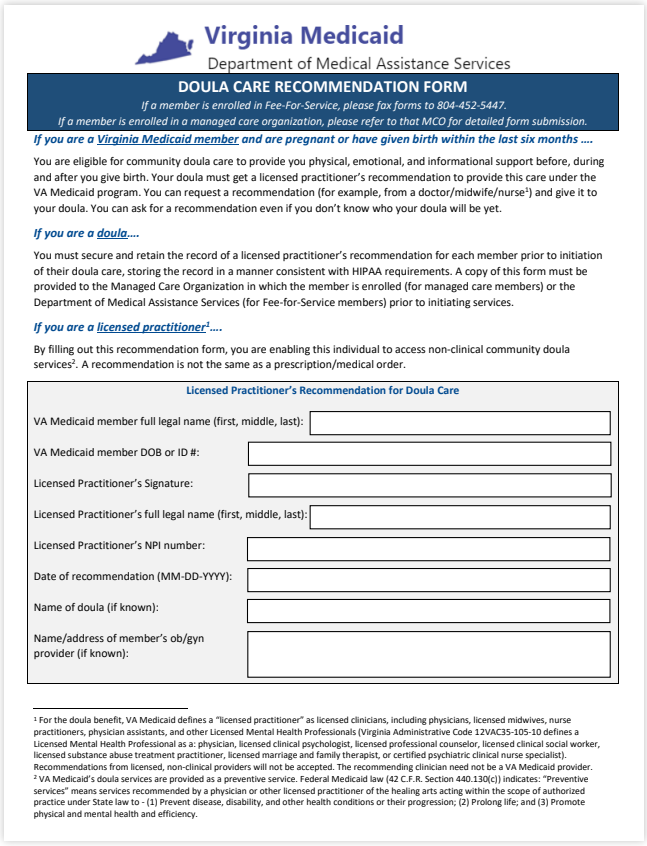
Benefit Overview

- Pregnant and postpartum members are eligible for:
  - eight prenatal or postpartum visits
  - one doula attendance at the delivery visit
- Members can be approved for additional visits after completion of the eight visits if it is deemed medically necessary.
- Members are not allowed multiple visits in the same day except when:
  - a prenatal visit occurs early in the day and the attendance at delivery is later
  - the attendance at delivery occurs early in the day and a postpartum visit is later

Initiating Doula Services

- Members must choose a community doula who has completed a Virginia Department of Health approved certification program.
- Doulas are then responsible for ensuring that the Doula Care Recommendation Form has been completed and signed by the member's licensed healthcare provider prior to initiating services.
- Doulas must retain a copy of the signed recommendation form with the member's medical records.

Fax Recommendation Forms to 757-352-2694 or 1-833-666-0706 (TTY: 711).



Virginia Medicaid
Department of Medical Assistance Services

DOULA CARE RECOMMENDATION FORM

If a member is enrolled in Fee-For-Service, please fax forms to 804-452-5447.
If a member is enrolled in a managed care organization, please refer to that MCO for detailed form submission.

If you are a Virginia Medicaid member and are pregnant or have given birth within the last six months ....

You are eligible for community doula care to provide you physical, emotional, and informational support before, during and after you give birth. Your doula must get a licensed practitioner's recommendation to provide this care under the VA Medicaid program. You can request a recommendation (for example, from a doctor/midwife/nurse[1]) and give it to your doula. You can ask for a recommendation even if you don't know who your doula will be yet.

If you are a doula....

You must secure and retain the record of a licensed practitioner's recommendation for each member prior to initiation of their doula care, storing the record in a manner consistent with HIPAA requirements. A copy of this form must be provided to the Managed Care Organization in which the member is enrolled (for managed care members) or the Department of Medical Assistance Services (for Fee-for-Service members) prior to initiating services.

If you are a licensed practitioner[1]....

By filling out this recommendation form, you are enabling this individual to access non-clinical community doula services[2]. A recommendation is not the same as a prescription/medical order.

Licensed Practitioner's Recommendation for Doula Care

VA Medicaid member full legal name (first, middle, last):	
VA Medicaid member DOB or ID #:	
Licensed Practitioner's Signature:	
Licensed Practitioner's full legal name (first, middle, last):	
Licensed Practitioner's NPI number:	
Date of recommendation (MM-DD-YYYY):	
Name of doula (if known):	
Name/address of member's ob/gyn provider (if known):	

[1] For the doula benefit, VA Medicaid defines a "licensed practitioner" as licensed clinicians, including physicians, licensed midwives, nurse practitioners, physician assistants, and other Licensed Mental Health Professionals (Virginia Administrative Code 12VAC35-105-10 defines a Licensed Mental Health Professional as a: physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist). Recommendations from licensed, non-clinical providers will not be accepted. The recommending clinician need not be a VA Medicaid provider.
[2] VA Medicaid's doula services are provided as a preventive service. Federal Medicaid law (42 C.F.R. Section 440.130(c)) indicates: "Preventive services" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to - (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency.

Care Management

- Members will receive communications and education regarding the new benefit.
- The Welcoming Baby team will conduct outreach to pregnant members.
- Welcoming Baby will complete the necessary documentation in our internal systems.
- If no provider recommendation form has been received:
  - The member will be contacted to verify doula contact information and provided education on the need for a completed provider form.
  - The doula will be contacted to request that the completed form is faxed to the Welcoming Baby Biscom line.

Doula Compensation and Billing

Covered Doula Services

- Doula services, rendered from date of conception through 180 days (six months) after delivery, may be reimbursed contingent on individual maintaining Medicaid eligibility.
- Doula services can only be provided in the community in clinician offices (if a doula is accompanying the member to a clinician visit) or in the hospital.
- Rendered doula care must be documented in the member's medical record.

Benefit Extensions

Benefit extensions will be considered medically necessary if the member is experiencing a potential complication or is at risk for or needs support managing one or more of the below:

- excessive anxiety
- breastfeeding knowledge, support, and assistance
- information about feeding and caring for the baby
- helping member or family learn to become comfortable with baby soothing and bonding methods
- promoting self-care
- postpartum depression

Sentara Health Plans **will** allow additional visits beyond the allowable nine with an authorization from an eligible provider.

Critical Elements

1. **NPI Number:** All claims submitted to Sentara Health Plans must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number will be rejected or denied.
2. **Modifier HD** is required with claims submission for covered doula services.
3. **Taxonomy Code 374J00000X** is required for billing. Claims received without the taxonomy code will be rejected or denied.
4. A **recommendation form** from an eligible provider is required to be submitted to MCO prior to providing services for a member.
5. **Diagnoses code Z32.2** (encounter for childbirth instruction) is required to bill doula services.

Billing Codes

Code	Description	Maximum Units Allowed Per Visit	Notes
99600-HD	Initial Prenatal Visit	90 minutes	Max six units of 15 minutes each (total of 90 minutes), one date of service
59425-HD	Standard Care, Prenatal Visit	60 minutes	Max three visits (initial prenatal and three prenatal visits) – bill in 15-minute increments, total of 60 minutes per visit
59409-HD	Labor Support, Vaginal Birth	1 unit (flat rate)	
59514-HD	Labor Support, C-section	1 unit (flat rate)	
59430-HD	Postpartum Care, Postpartum Visit	60 minutes	Max four visits—bill in 15-minute increments, total of 60 minutes per visit
99199-HD	Incentive Mother Postpartum	1 unit (flat rate)	
99199-HD	Incentive Newborn* Postpartum	1 unit (flat rate)	*Must be billed under the newborn's Medicaid ID

Incentive Payments

To receive the incentive payments, doulas need to have performed at least one postpartum visit. A $50 value-based incentive payment can be received by the doula if the client is seen by an obstetric clinician for one postpartum visit. A $50 value-based incentive payment can be received if the newborn is seen by a pediatric clinician for one visit after birth.

Brain Injury Services (BIS)

Benefit Overview

Traumatic brain injury (TBI) Diagnosis – A TBI is defined as brain damage due to a blunt blow to the head, a penetrating head injury, injury resulting in compression to the brain, severe whiplash causing internal damage to the brain, or head injury secondary to an explosion.

Exclusions: Brain damage secondary to other neurological insults (e.g., infection of the brain, stroke, anoxia, brain tumor, Alzheimer's disease, and other conditions causing dementia, and other neurodegenerative diseases) is not considered to be a TBI.

Both criteria must be met to approve Brain Injury Service (BIS) care management.

Initiating Services

Upon receipt of a referral, and prior to the delivery of BIS care management services, the BIS care manager must complete a BIS assessment. The BIS care manager will conduct a face-to-face evaluation at the members residence to:

- determine the member's qualifying diagnosis of TBI as defined
- initiate the Mayo-Portland Adaptive Index-4 (MPAI-4) assessment related to the severity of the brain injury and the member's level of functioning once the TBI diagnosis has been confirmed
- interpret the MPAI-4 results for comprehensive service planning purposes
- implement the person-centered planning process

As part of the intake process, the BIS care management provider must collect existing medical documentation that substantiates the member's diagnosis of a TBI as defined.

If there is no documented diagnosis, then the BIS care manager and/or the member's assigned Sentara Health Plans care manager will assist the member in accessing a physician who can assess further and document whether the member has an eligible BIS care management diagnosis.

Sentara Health Plans will support new cases by assisting the BIS care management providers with locating active service providers from the provider network.

BIS care management providers should communicate with Sentara Health Plans to coordinate care for members not meeting the DMAS definition of TBI criteria.

Care Management

Following the completion of the BIS assessment and approval for BIS care management services by Sentara Health Plans, BIS care management service includes but is not limited to the following activities:

- assessing and planning services
- linking the member to services and supports identified in the member support plan, assisting the member directly for the purpose of locating, developing, or obtaining needed services and resources
- coordinating services and service planning with other agencies and providers involved with the member, enhancing community and service integration
- making collateral contacts to promote the implementation of the member service plan and integrated care
- monitoring the member to assess ongoing progress and ensuring that authorized services are delivered and to prevent any disruptions in services
- educating and counseling the member, family, or legal representative to guide them to develop supportive relationships that promote the member service plan for the direct benefit of the member

Claims/Billing – Service Limits

Other care management services may not be reimbursed while BIS care management is authorized. Refer to the DMAS Provider Manual for detailed claims, billing, and service limits. All BIS cases are reviewed with consideration to the member's unique needs and situation.

Service Limits/Overlaps	
Limits	**Description**
Monthly – S0280/S0281	One unit per month
Place of Service	02, 03, 04, 10. 11, 12, 13, 14, 19, 20, 21, 22, 23, 32, 33, 51, 53, 54, 55, 56, 57, 71, 72, 93, 99
Rolling Year – S0280	Limit two per year unless a brain injury triggering event*
Overlap S0280 and S0281	Only one unit per month; cannot overlap between same BIS providers
Overlap S0281 and S0280	Overlap is allowed between BIS care management provider A and BIS care management provider B – submitting an assessment
Overlap S0281	Only one BIS care management provider per month – one unit per month
Overlaps Allowed With Limits	All community services except case management codes
Case Management Overlap Codes Not Allowed	G9012, T1016 (Tx Foster Care care management), T1017 (ID care management), H0023 (MH care management), T2023 (DD care management), H0006 (ARTS care management)
DD Waiver LOC	BIS care management services cannot overlap with an open DD Waiver level of care

Special Needs Plan (SNP) and Model of Care (MOC) Overview

This serves as a brief overview of the Sentara Health Plans Model of Care, with more detailed provider education available and **required for SNP providers** in the **Model of Care Provider Guide**. You are also encouraged to review the Sentara Health Plans Medicaid Provider Manual.

The Model of Care is an approach to identifying targeted populations for outreach, care management, and disease management, which specifies expectations for member engagement, assessment, care planning, interdisciplinary team meetings, and other interventions to improve member outcomes and experience. SNP MOCs are designed to optimize the well-being of members, particularly our aging, vulnerable, and chronically ill.

An SNP is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be:

- an institutionalized individual
- dual eligible for Medicare and Medicaid
- an individual with a severe or disabling chronic condition, as specified by CMS

An SNP may be any type of MA CCP, including either a local or regional preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan.

There are three different types of SNPs:

- Chronic Condition SNP (C-SNP)
- Dual-eligible SNP (D-SNP)
- Institutional SNP (I-SNP)*

Sentara Health Plans MOC Plans

Sentara Health Plans MOC is designed to ensure the provision and coordination of specialized services that meet the needs of the SNP-eligible beneficiaries. Our SNP plans include:

- Sentara Community complete (HMO D-SNP)
- Sentara Community Complete Select (Partial Dual D-SNP)
- Sentara Medicare Engage (C-SNP)
  - Diabetes
  - Cardiovascular Disease
  - Congestive Heart Failure
  - Lung

Note: Each Special Needs Plan has specific eligibility rules.

Chronic SNP: Sentara Medicare Engage – Diabetes and Heart (HMO C-SNP) and Sentara Medicare Engage - Lung (HMO C-SNP). The C-SNP (Chronic Condition Special Needs Plan) is a specialized care coordination plan (program) that is an extension of our Medicare Advantage plan. The Centers for Medicare & Medicaid Services (CMS) requires that you have a Medicare Advantage plan to qualify for a C-SNP. C-SNP is solely Medicare related.

Member Verification and Enrollment in C-SNP – Time Sensitive

Member enrollment into C-SNP is extremely time sensitive. CMS allows **seven days** to complete the verification process. If enrollment and verification are not completed within this time frame, the member cannot be enrolled in the C-SNP plan.

*It is critical that providers **verify** the member has been diagnosed with one or more of the qualifying chronic condition(s) on the **same day the request is received**.*

**Sentara Health Plans does not offer I-SNP*

Required Model of Care Education

Providers are required to review the **Model of Care Provider Guide (MCPG)** within 30 days of their initial orientation date as a newly contracted provider (and by January 31 of each subsequent year). **Attestation is required and will be recorded by provider (practice/facility) name, 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 located at the link below. The attestation must be executed by the provider and verified by Sentara Health Plans prior to Sentara Health Plans signing and returning the SCA.

Providers may access the attestation for the Sentara Health Plans Model of Care guide on the **Sentara Health Plans provider education web page.**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Overview

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

Sentara Health Plans' Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provider Desk Reference is also available for review or printing on the **Sentara Health Plans' website**. You are also encouraged to review the Sentara Health Plans Medicaid Provider Manual.

Contract Alignment

The majority of the consolidated Sentara Health Plans provider agreement amended with the implementation of Cardinal Care incorporates existing requirements from the M4 and CCC+ contracts, **effective April 1, 2023**.

Helpful Resources

Explore these resources on the **DMAS website**:

- DMAS Provider Manuals
- EPSDT Supplement B
- MES Provider Portal
- Commonwealth of Virginia Referral Directory by City/County

Sentara Health Plans Quick Reference Resources

Explore Sentara Health Plans provider support resources on our **website**.

- Sentara Health Plans Commercial and Medicare Provider Manual
- Sentara Health Plans Medicaid Provider Manual
- Provider Orientation
- Provider Toolkit
- Sentara Health Plans Claims and Billing Quick Reference Guide

E-booklets

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Desk Reference
- Doing Business With Sentara Health Plans

Slide Presentations

- Transitioning to Cardinal Care