Sentara®
Health Plans

Provider Newsletter

Summer 2024

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Health Plans

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Important Update Regarding Case Management Services

Effective June 1, Sentara Health Plans announced that our internal case management team will take over the services previously provided by AccordantCare®.

By receiving these services directly from Sentara Health Plans, our members will experience several benefits:

- **Coordinated Care:** The case manager will work closely with the provider to ensure seamless care.
- **Single Point of Contact:** Members and providers will have one dedicated contact for all case management and care coordination needs.
- **Immediate Updates:** All departments at Sentara Health Plans can efficiently update the care plan, enhancing health outcomes.

This transition was automatic, and it required no action from you.

A Sentara Health Plans case manager will reach out to impacted members by phone to review their current care plan and address healthcare needs. If a member needs to speak to a case manager before they are contacted, they can call **1-866-503-2730** between 8 a.m. and 5 p.m.

Sentara Health Plans is committed to providing your patients and our members with the best possible care and support.

Dario Health

Dario Health has partnered with Sentara Health Plans to help individuals with diabetes manage their health. This program offers comprehensive digital therapeutic solutions that address chronic conditions like diabetes through an integrated technology platform. Dario provides benefits that focus on promoting behavioral changes for better health using evidence-based interventions, specialized coaching, and more.

The Dario program is covered by Sentara Health Plans at **no cost** for eligible Medicaid members with type 2 diabetes. Dario can improve your patients with A1C results of ≥8.0 by providing streamlined support to develop and maintain a healthier lifestyle. To learn how to enroll your patients, and learn more about Dario, **click here**.

Sentara To Home

Sentara To Home is designed with the patient leaving the hospital, and going home, in mind. Our goal is to extend our care to our patients after they leave the hospital, making their transition to home simple and convenient.

With Sentara To Home, patients can purchase medications, home medical equipment, and other healthcare needs all before leaving the hospital.

The following products and services are available with Sentara To Home:

- Prescription medications
- Over-the-counter medications (cough and cold medications, pain medications, first aid products, vitamins, and nutritional supplements)
- Durable medical equipment including canes and walkers, walker bags, cane tips and cup holders, and complex wound care items
- Aids for daily living including reachers, grabbers, and car caddies
- Bath and bedroom safety items including raised toilet seats, bath benches, and grab bars for showers and baths

We also offer specialty items for unique health needs:

- Diabetic and cardiac care items including monitors, scales, socks, foot care products, and travel cases
- Orthopedic care items including wrist, ankle, and knee braces
- Rehabilitation items including easy-to-grab silverware, over-the-door shoulder pulleys, exercise bands, and therapeutic warm and cold packs
- Incontinence supplies including adult diapers and cleansers

Sentara To Home is available at the following Sentara Hospitals:

- All Hampton Roads hospital locations
- Sentara Martha Jefferson Hospital, Charlottesville, VA
- Sentara Rockingham Memorial Hospital, Harrisonburg, VA

Welcoming Baby℠

Welcoming Baby Program

Welcoming Baby is Sentara Community Plan's incentive-based maternal healthcare program for our Medicaid members. Our members are encouraged to seek timely and consistent prenatal and postpartum care with their providers. Through the Welcoming Baby Program, members receive reminders, education, and incentives if they receive their first prenatal visit within 42 days of enrolling with Sentara Community Plan (or within their first trimester). Members receive reminders and education and are eligible for an incentive if they receive their timely postpartum provider visit within 7-84 days of giving birth.

What does the program include?

- Pregnancy after conception
- Birth
- Postpartum care for up to 12 months
- Watch Me Grow child outreach to babies from birth to 15 months

What do your patients receive from this program?

- One-on-one supportive services from a certified community health worker (outreach representative) and maternity case manager and/or behavioral health maternity care coordinator
- Screening and referral to maternity case managers/care coordinators for care planning and goal setting
- Education - community referrals for identified needs
- Family planning – Long-Acting Reversable Contraception (LARC) and birth spacing education
- Baby showers (virtual and in-person)
- Access to breast pumps
- Maternal/child education series classes
- Referrals to parenting, breastfeeding classes, and lactation services
- Hospital tours (virtually and in-person)
- Timeliness of Care incentives

Contact the Welcoming Baby Outreach Team:
Monday–Friday, 8 a.m.–5 p.m.

Phone: **1-844-671-2108 (TTY: 711)**
Email: **welcomingbaby@sentara.com**

OB Registration Program: Early Identification of Pregnancy

- OB Registration Incentive Program for Welcoming Baby Medicaid: Providers are eligible to receive a $25 incentive for referring pregnant patients to Sentara Community Plan's Welcoming Baby Program upon identification of pregnancy.
- All providers must fill out a **Welcoming Baby OB Registration Form**, fax it to outreach at **1-804-799-5117**, and submit a claim using the code G9001.
- Providers can also email us at **welcomingbaby@sentara.com**.

Sentara® Health Plans

DMAS Updates

- Documentation Tips: Provider Education for Service Facilitators and Personal Care Agencies

Documentation Tips: Provider Education for Service Facilitators and Personal Care Agencies

The Quality Management (QMR) Team at Sentara Health Plans conducts quality management reviews assigned by the Department of Medical Assistance Services (DMAS), which include a review of documentation used in the provision of consumer-directed service facilitation and agency-directed personal care. This article was prompted by common issues observed and will cover tips to help service facilitators (SFs) and personal care agencies (PCAs) accurately complete the required documentation. Focusing on three main areas, the DMAS 99 Assessment form, the DMAS 97 A/B service plan form, and other general documentation areas, should improve provider documentation.

The DMAS 99 Assessment Form

This form is completed for initial, routine, and six-month reassessment visits. It is important to select the correct visit type. Old forms should not be used. It is required to address every item on the form by providing information or by marking that the item is not applicable (N/A). The Start of Care date is the date the provider started service. If the member is not oriented and appropriate in behavior, it is important to specify what the issue is and identify the source of the information. Medications, medical needs, therapies, and hospitalizations should also be addressed as these can change over time.

While the old form had a line at the top of the second page for the client's name, which has been removed from the current form, the page can be identified by writing the member's name in the top margin. Important information includes the current supports for the member, such as who is functioning as the primary caregiver for the member, what person or persons are paid to attend to the member, who is directing the care of the member, and whether these people live in the home with the member. The time period that the member should expect to have aide support should be documented and the total hours and schedule should match what is documented on the service plan. Some members would benefit from, or perhaps have, a Personal Emergency Response System, or PERS. The Sentara Health Plans care coordination staff can assist a member in obtaining PERS or other services needed. The schedule of past and anticipated home visits should be documented. There are a few places on the form that request information specifically from service facilitators or agency supervisors. Documentation should include if the aide is present at the home visit. Additional information can be included on the free text lines or a separate progress note. Because the DMAS 225 form tracks where the member is receiving care, it is important to document the date of the most recent DMAS 225 form.

Only authorized signers should sign the form. The paid attendant should not sign for the member. The provider should sign with a legible signature and include credentials. The link for the most current DMAS 99 document is located **here**.

The DMAS 97 A/B Service Plan Form

This form is completed to define the expected duties of the paid attendant, whether hired by the member (or member's representative) or provided by the agency. It should reflect the member's current needs and the approved hours from the health plan. Instrumental activities of daily living tasks (IADLs) should require two hours or less per day for the household, even if more than one member is served in the same home. The scoring at the bottom of the first page gives a guide to the number of hours considered reasonable; if those hours are exceeded, supportive documentation is required.

If the member requires a split shift, two service plans are required, one to cover each period of service. The current version of the DMAS 97 A/B form can be obtained **here**.

Other Documentation Tips

When admitting a new member, it is important to have documentation that the member was offered a choice of services. Often this form is included in the Uniform Assessment Instrument (UAI), and some providers have created a similar form if needed. New members benefit from more frequent home visits, and 30-day and 60-day follow-up visits are recommended. For new members and ongoing members using consumer-directed services, document the training provided when those billing codes are used. If an error is made on any form, draw a single line through the error, initial and date the error, and document the correction. If the error is found later, follow the established guidelines for late entries to explain the error and correction.

For members using respite care in addition to personal care, two sets of documents are required and are kept separate in the member's file, one for personal care and one for respite care.

All people paid through the Commonwealth Coordinated Care (CCC) Plus Waiver Program to provide services are required to meet all the requirements in the CCC Plus Waiver Manuals. The Waiver Manuals can be downloaded from the DMAS portal **here**.

During the review process, the QMR Team works with providers to correct documentation deficiencies. The QMR Team hopes this review has been helpful for contracted service facilitators and personal care providers.

Sentara®
Health Plans

Quality Improvement

- Dr. Melvin T. Pinn, Jr. Quality Excellence Award
- Quality Improvement Project: Raising Awareness on Breast Cancer Screenings
- Chronic Care Improvement Program
- Encouraging Diabetes Education to Help Members Plan for Sick Days
- Diabetes Transition Program (Medicaid and D-SNP)
- Short Acting Beta Agonist (SABA) Program (Medicaid)
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- Catch-Up on Well-Child Visits and Recommended Vaccinations
- CAHPS – A Patient Experience Survey

Dr. Melvin T. Pinn, Jr. Quality Excellence Award

Formerly known as the Practitioner Golden Globe Award, the newly named **Dr. Melvin T. Pinn, Jr. Quality Excellence Award** was founded and co-founded by the late Dr. Melvin T. Pinn, Jr. and Jamie McPherson in 2006. This prestigious award was created to recognize physicians for demonstrating their commitment to quality care and safety, improving member outcomes, and community involvement. Sentara Health Plans will annually recognize an outstanding participating practitioner who promotes safe clinical practice and delivery of quality care, and who voluntarily broadens their scope of practice through education and community involvement. Contracted and/or affiliated physicians, physician office staff, and members are encouraged to complete the nomination form located on the Sentara Health Plans website for review and consideration to be recognized for ***quality excellence***.

Nominations will be accepted from January 1 to December 31 and will be awarded the following year after all nominations are reviewed. The quality department will select the winner based on improving outcomes for the Healthcare Effectiveness Data and Information Set (HEDIS®) information supplied in the nomination.

For more information about the Quality Excellence Award and to complete the nomination form, please visit **sentarahealthplans.com/providers/qea**.

The Sentara Health Plans quality department is waiting to receive your nomination and is excited to award the next recipient!

Quality Improvement Project: Raising Awareness on Breast Cancer Screenings

Increasing breast cancer screenings for eligible Dual Eligible Special Needs Plan (D-SNP) members is the focus of the new Sentara Health Plans Quality Improvement Project (QIP). This project was implemented in January 2024 and will run through December 2026. Through education and community outreach, using Sentara's mobile mammography van, we hope to increase breast cancer screenings in rural and underserved areas.

The measurement methodology used for this project will be the HEDIS measure BCS-E. The target population is the percentage of members 50-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer during the measurement year. Members are considered compliant having had one or more mammograms any time on or between October 1 two years before the measurement period and the end of the measurement period.[1]

The American Cancer Society reports breast cancer as being the most diagnosed cancer and the second leading cause of cancer-related deaths among American women in the United States. One in eight women in the U. S. will be diagnosed with breast cancer in their lifetime, but early screening and detection can make all the difference. When caught early, the five-year relative survival rate is 99%.[2] Mammograms are essential for early detection of breast cancer. Women aged 50-74 should have a breast cancer screening every two years, according to the U.S. Preventative Services Task Force's recommendations.

D-SNP members are eligible for a $50 reward under the Medicare Healthy Rewards program if they complete a mammogram this year.

Our Sentara mobile mammography vans travel to dozens of sites across Virginia and North Carolina throughout the year. Sentara mobile mammography vans do not require a physician's referral. Members will need to provide their primary care physician's contact information.

Screening mammograms should not be completed utilizing the mobile mammography van when a member:

- Is experiencing a serious breast problem, such as a lump, thickening, bloody discharge from the nipple, recently inverted nipple, "orange peel" texture to the skin, redness or discoloration of the breast, or any other recent changes
- Is under the age of 35
- Has a personal history of breast cancer
- Has their first mammogram after a breast biopsy, surgery, or reconstruction
- Has a follow-up mammogram less than 12 months after their most recent regularly scheduled mammogram

Help eligible members plan a visit to a Sentara mobile mammography van:

Hampton Roads and North Carolina:

- To schedule your appointment, call **757-736-0040**.

Harrisonburg/Shenandoah Valley:

- To schedule your appointment, call **540-689-6000** (select option 2).

Northern Virginia:

- To schedule your appointment, call **703-523-1560**.

[1] *National Committee for Quality Assurance. (2024). HEDIS 2024 Volume 2: Technical Specifications for Health Plans NCQA*

[2] *Information taken from Breast Cancer Facts & Stats | Incidence, Age, Survival, & More (nationalbreastcancer.org)*

Chronic Care Improvement Program

Sentara Health Plans Chronic Care Improvement Program (CCIP) is designed to promote effective chronic disease management, improve care, and health outcomes for enrollees with chronic conditions. As an integral part of the Quality Improvement (QI) Program, CCIP initiatives are performed in compliance with the Centers for Medicare and Medicaid Services (CMS) and conducted over a three-year period.

Sentara Health Plans' new CCIP project will focus on improving Glycemic Status Assessment for members with diabetes enrolled in the Medicare Advantage, D-SNP, and Chronic Condition Special Needs Plan (C-SNP) populations. Members who lower their HbA1c to less than 8% have opportunities to enhance their overall health outcomes, reduce their risk of cardiovascular disease, and diabetic complications. These CCIPs were implemented in January 2024 and will run through December 2026.

The measurement methodology used for this project will be the HEDIS measure – Glycemic Status Assessment or (GSD). The target population is the percentage of members 18–75 years of age with diabetes (Types 1 and 2) whose most recent glycemic status hemoglobin A1c (HbA1c) or Glucose Management Indicator (GMI) was at the following levels during the measurement year:

- Glycemic Status < 8%
- Glycemic Status > 9%

The member is compliant if the most recent glycemic status assessment has a result of < 8%. The member is considered not compliant if the most recent glycemic status assessment result is ≥ 8%, is missing a result, or if a glycemic status assessment was not completed during the measurement year. If there are multiple glycemic status assessments on the same date of service, the lowest result will be used.

HEDIS Measures and Technical Resources - NCQA. (2024, August 1). NCQA. **https://www.ncqa.org/hedis/measures/**

Encouraging Diabetes Education to Help Members Plan for Sick Days

When diabetics have the flu or a cold, it is more difficult to keep their blood glucose levels within the desired range because of the hormones that the body releases in response to stress and illness. Ensuring blood glucose levels remain within the respective target range helps to minimize complications. Having a plan for sick days will help diabetics better control their diabetes and promote health and wellness:

- Continue taking diabetes medication, as normal, or per provider instructions.
- Use over-the-counter medications wisely as some can raise blood glucose levels; consult their physician.
- Check blood glucose levels every three to four hours.
- Drink extra calorie-free liquids to prevent dehydration.
- Try to eat as normal to maintain normal blood glucose levels.
- Use the 15-15 rule to treat low blood glucose levels: have 15 grams of carbohydrates to raise blood glucose levels and check it after 15 minutes. Repeat steps if still below the target range.
- Get adequate rest.

Encouraging Diabetic Members to Watch for Signs of Diabetic Ketoacidosis (DKA)

It is recommended for diabetics to test for ketones every four to six hours when feeling sick and contact their physician for any of the following warning signs of DKA:

- High blood glucose
- Frequent urination
- Nausea, vomiting, or abdominal pain
- High ketones
- Drowsiness/confusion
- Difficulty breathing
- Thirst or dry mouth
- Dry or flushed skin
- Fruity smelling breath

Source: Diabetes and Planning for sick Days | ADA. (n.d.-b). **https://diabetes.org/getting-sick-with-diabetes/sick-days**

Diabetes Transition Program (Medicaid and D-SNP)

This program is meant to address key reasons why members have admissions or readmissions for a primary diabetic condition including, but not limited to, the following:

- Knowledge deficit regarding proper management of diabetes
- Lack of access to medications needed to control blood sugar levels
- Lack of means to test their blood glucose, no working mete to check their blood sugar as directed by their physician
- Transportation to medical appointments
- Social determinants such as access to food assessment
- Ambivalence to lifestyle changes
- Consideration of behavioral/mental health needs

This program includes completing condition-specific assessments, providing individual education, and developing an individualized care plan for progress tracking and goal completion to improve health outcomes.

Targeted Members: Members admitted/ readmitted to the hospital with a primary diagnosis of any diabetes code.

Short Acting Beta Agonist (SABA) Program (Medicaid)

Chronic Care Management staff offers the following:

- Condition-specific assessment
- Completes individualized education and education on benefits
- Individualized care planning to improve member outcomes
- Referrals to community resources

A letter is sent to the primary care provider (PCP) with notification of the number of rescue medications the member is filling/refilling for notification that asthma is not under control.

Targeted Members: Members who have been prescribed three or more SABAs or have not filled their controller/maintenance medication in the past 90 days and/or members who have not had a follow-up appointment with their PCP after an asthma-related emergency department visit.

Goal: Identify and assist members who fit the above criteria via outreach, discussing asthma triggers, helping the member find a PCP if they do not have one, and follow up to ensure care plan goals are met.

What Can Providers do to Ensure Members are Keeping Their Eyes Healthy?

Here are a few tips providers can recommend to members to help prevent vision loss.
Below are simple guidelines for maintaining healthy eyes.

- **Have a comprehensive eye exam.**

  When it comes to common vision problems, some people don't realize they could see better with glasses or contact lenses. In addition, many common eye diseases, such as glaucoma, diabetic eye disease, and age-related macular degeneration, often have no warning signs. A dilated eye exam is the only way to detect these diseases in their early stages.

- **Wear sunglasses.**

  Sunglasses are a great fashion accessory, but their most important job is to protect your eyes from the sun's ultraviolet rays. When purchasing sunglasses, look for ones that block out 99 to 100% of both UV-A and UV-B radiation.

- **Maintain blood sugar levels.**

  90% of blindness caused by diabetes is preventable.

- **Give your eyes a rest.**

  Encourage the 20-20-20 rule: Every 20 minutes, look away about 20 feet in front of you for 20 seconds. This short exercise can help reduce eyestrain.

- **Know your family's eye health history.**

  It's important to know if anyone has been diagnosed with an eye disease or condition since many are hereditary. This information will help to determine if one is at higher risk for developing an eye disease or condition.

- **Clean hands and contact lenses properly.**

  To avoid the risk of infection, hands should be washed thoroughly before putting in or taking out contact lenses. Make sure to disinfect contact lenses as instructed and replace them as appropriate.

- **Maintain a healthy weight.**

  Being overweight or obese increases your risk of developing diabetes and other systemic conditions, which can lead to vision loss, such as diabetic eye disease or glaucoma. If you're having trouble maintaining a healthy weight, talk to your doctor.

- **Wear protective eyewear.**

  Wear protective eyewear when playing sports or doing activities around the home. Protective eyewear includes safety glasses and goggles, safety shields, and eye guards specially designed to provide the correct protection for the activity in which you're engaged.

- **Eat right to protect your sight.**

  Eating a diet rich in fruits and vegetables—particularly dark leafy greens, such as spinach, kale, or collard greens—is important for keeping your eyes healthy, too. Research has also shown there are eye health benefits from eating fish high in omega-3 fatty acids, such as salmon, tuna, and halibut.

- **Quit smoking or never start.**

  Smoking is as bad for your eyes as it is for the rest of your body. Research has linked smoking to an increased risk of developing age-related macular degeneration, cataracts, and optic nerve damage, all of which can lead to blindness.

Source: Vision and eye health. (2023, November 29). Vision and Eye Health. **https://www.cdc.gov/vision-health/?CDC_AAref_Val=https://www.cdc.gov/visionhealth/risk/tips.htm#comprehensive-eye-exam**

Catch-Up on Well-Child Visits and Recommended Vaccinations

Many children missed check-ups and recommended childhood vaccinations over the past few years. Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend children catch up on routine childhood vaccinations and get back on track for school, childcare, and beyond.

Well-child visits and recommended vaccinations are essential and help make sure children stay healthy. Children who are not protected by vaccines are more likely to get diseases like **measles** and **whooping cough**. These diseases are extremely contagious and can be very serious, especially for babies and young children. In recent years, there have been outbreaks of these diseases, especially in communities with low vaccination rates.

Well-child visits are essential for many reasons, including:

- Tracking growth and developmental milestones
- Discussing any concerns about your child's health
- Getting scheduled vaccinations to prevent illnesses like measles and whooping cough (pertussis) and **other serious diseases**

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger:

Getting children and adolescents caught up with recommended vaccinations is the best way to protect them from a variety of **vaccine-preventable diseases**. **Please review the Sentara Health Plans preventive health guidelines for a schedule outlining the vaccines recommended for each age group.**

Source: Well-Child visits and recommended vaccinations are essential. (2023, March 21). Centers for Disease Control and Prevention. **https://www.cdc.gov/vaccines/parents/visit/vaccination-during-COVID-19.html**

CAHPS – A Patient Experience Survey

Each year, CMS collects patient experience feedback using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey measures the patient's perception of the quality of care they receive. Sentara Medicare wants to partner with providers in improving the experience of our members, your patients. Patient experience is a year-round commitment, one that Sentara Medicare takes seriously! Members with good experience in the healthcare system have better health outcomes.

Patient Experience Matters. Here are some resources for you:

- **Patients who are satisfied are more likely to adhere to treatment plans.**
- **Patients who feel heard and respected are empowered.**
- **Patients who have a strong provider relationship are loyal.**
- **Patients who are treated with dignity have a greater sense of well-being.**

Strategies for Improving Patient Experience

Communication:

- Listen actively.
- Use plain language.
- Encourage questions.

Empathy:

- Acknowledge preferences.
- Share decision-making.
- Put yourself in their shoes.

Access:

- Employ telehealth.
- Prepare for visits.
- Triage calls.

Personalization:

- Consider culture.
- Adjust for health literacy.
- Empower with knowledge.

Follow-through:

- Call with results.
- Ask about prescriptions.
- Coordinate with specialists.

Growth:

- Seek feedback about patient experience.
- Implement continuous improvement projects.
- Train staff on best practices.

Learn more about how the Centers for Medicare & Medicaid Services (CMS) measures patient experience **here.**

Sentara®
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Authorizations, Medical Policies, and Billing

- Authorization Updates, Effective August 1, 2024
- New Quarterly CPT/HCPCS Codes, Effective July 1, 2024
- Authorization Requirements for COVID-19 (Medicare/Medicaid/Commercial)
- Authorization Requirements for Two Behavioral Health Services (Medicaid)
- Updates to Hearing Benefit for Medicaid Members 21 Years of Age and Older
- Split Billed Services with Modifier TC and 26 (Medicaid/Medicare)
- Commercial Fully Funded Plans Prior Authorization Updates, Effective October 1, 2024

Authorization Updates, Effective August 1, 2024

Visit our website to view the most recent authorization updates. Access all current behavioral health, durable medical equipment, imaging, medical, obstetrics, pharmacy, and surgical policies at **sentarahealthplans.com/providers/clinical-reference/medical-policies**.

New Quarterly CPT/ HCPCS Codes, Effective July 1, 2024

New CPT and HCPCS codes effective July 1, 2024, for drugs, professional services and procedures, supplies, durable medical equipment, and quality measures. Coverage determination and authorization requirements, Medicare, and Medicaid, are available via the Prior Authorization List on the Sentara Health Plans website.

- 67 New HCPCS codes
- 64 New CPT codes

Note: The following vaccines will be covered upon Food and Drug Administration (FDA) approval:

Procedure Code	Name
90637	VACC QIRV MRNA 30MCG/.5ML IM
90638	VACC QIRV MRNA 60MCG/.5ML IM
90684	PCV21 VACCINE IM

- Deleted codes
  - 13 codes were termed effective July 1, 2024

Authorization Requirements for COVID-19 (Medicare/Medicaid/Commercial)

On March 22, 2024, the FDA released an emergency use authorization for the PEMGARDA (pemivibart) investigational monoclonal antibody product for pre-exposure prophylaxis of COVID-19 in certain adults and adolescents.

HCPCS Code	HCPCS Short Descriptor	Drug Name	Vaccine/Procedure Name	Medicare/ Medicaid/ Commercial Authorization Required	Effective Dates
Q0224 (Product Code)	Inj, pemivibart, 4500 mg	Invivyd	Injection, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known SARS-CoV-2 exposure, and who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, and are unlikely to mount an adequate immune response to COVID-19 vaccination, 4500 mg	NO	June 1, 2024
M0224 (Administration Code)	Pemivibart infusion	Invivyd	Intravenous infusion, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known SARS-CoV-2 exposure, who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, includes infusion and post administration monitoring	NO	June 1, 2024

Note: Code changes and deleted codes are also updated on the **Sentara Health Plans website**.

Authorization Requirements for Two Behavioral Health Services (Medicaid)

Authorization requirements for two behavioral health procedure codes have been updated to reflect No Authorization Required effective July 1, 2024, for the Medicaid line of business.

DMAS requirements:

- Limit: 1 unit per month
- Overlap: Cannot bill H0023 and H0006 in the same calendar month

Note: Authorization will not override limit.

Procedure Code	Name	Medicaid Authorization Required	Effective Date
H0023	Mental Health Case Management	NO	July 1, 2024
H0006	Substance Use Case Management	NO	July 1, 2024

Note: Code changes and deleted codes are also updated on the **Sentara Health Plans website**.

Updates to Hearing Benefit for Medicaid Members 21 Years of Age and Older

The following 38 codes are being removed from the NationsHearing benefit. These services will now be reimbursed by the health plan under the medical benefit.

Medical Hearing codes reimbursed by Sentara Health Plans:

92551	92568	92587	92620
92552	92571	92588	92621
92553	92572	92594	92625
92555	92575	92595	92626
92556	92576	92596	92627
92557	92577	92597	92630
92562	92579	92601	92633
92563	92582	92602	92700
92565	92583	92603	
92567	92584	92604	

Routine Screening Hearing codes will be reimbursed by NationsHearing:

92590	V5100	V5250	V5273
92591	V5110	V5251	V5274
92592	V5120	V5252	V5275
92593	V5130	V5253	V5281
V5008	V5140	V5254	V5282
V5010	V5150	V5255	V5283
V5011	V5160	V5256	V5284
V5014	V5200	V5257	V5285
V5020	V5241	V5258	V5286
V5030	V5242	V5259	V5287
V5040	V5243	V5260	V5288
V5050	V5244	V5261	V5289
V5060	V5245	V5262	V5290
V5070	V5246	V5263	V5298
V5080	V5247	V5264	V5299
V5090	V5248	V5266	
V5095	V5249	V5267	

Note: Code changes and deleted codes are also updated on the **Sentara Health Plans website**.

Split Billed Services with Modifier TC and 26 (Medicaid/Medicare)

If prior authorization is required for any Diagnostic Test with a PC/TC Indicator of "1" on the CMS Physician Fee Schedule, then the authorization requirement will extend to the entire Global Service.

If no authorization is on file for the Technical Component, then the Professional Component, billed with modifier 26 will also be denied.

Note: Code changes and deleted codes are also updated on the **Sentara Health Plans website**.

Commercial Fully Funded Plans Prior Authorization Updates, Effective October 1, 2024

Authorization requirements for 173 procedure codes will be updated effective October 1, 2024, for commercial fully funded lines of business.

Sentara® Health Plans

Pharmacy

- Pharmacy Formulary Updates

Pharmacy Formulary Updates

The Sentara Health Plans Pharmacy and Therapeutics Committee (P&T) meets at least bimonthly to provide strategic clinical direction on formulary management and clinical programs. Clinical recommendations made by the committee may result in drug formulary placement updates. These updates help ensure that the most clinically appropriate, cost-effective formulary drugs remain accessible and that contractual obligations are maintained.

Formulary updates for our commercial, exchange, FAMIS, Medicaid, and Medicare lines of business can be found on our **website**.

Once at the '**Formularies and Drug Lists**' page, choose the appropriate line of business. The '**Quarterly Pharmacy Changes**' document(s) are updated quarterly. Updates are posted a minimum of 60 days prior to implementation.

Sentara®
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Important Updates and Reminders

- Register for Our Upcoming Webinars

Register for Our Upcoming Webinars

Mark your calendars to join our upcoming quarterly educational sessions. **Visit our website** to learn more and register. Presentations from previous sessions are also available.

Medical Provider Touchpoint

- August 7, 2024 – 10 a.m.

Provider Quality Care Learning Collaborative

- August 7, 2024 – 12 p.m.

Let's Talk Behavioral Health

- August 13, 2024 – 1 p.m.