Sentara®
Health Plans

Doing Business With Sentara Health Plans

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Purpose of the Guide

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

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

PRSS Enrollment

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

Main points:

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

Member Rights

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Be furnished healthcare services in accordance with 42 CFR §§ 438.206 through 438.210.
- Be treated with respect and with due consideration for their dignity and privacy.
- Call member services to file a complaint/grievance about Sentara Health Plans, or to file an appeal if they are not happy with the answer to their inquiry (question), complaint/grievance, or care given.
- Choose their personal Sentara Health Plans doctor/primary care physician (PCP). You can find the **Provider Directory** online at **sentarahealthplans.com.** Contact member services for assistance.

Member Rights (continued)

- Change their personal Sentara Health Plans doctor and choose another one from our Provider Directory. The Provider Directory can be found online, or call member services for assistance.
- Have healthcare services 24 hours a day, 365 days a year, including urgent, emergency, and post-stabilization services.
- Have their doctor tell them about all treatment options and alternatives, presented in a manner that can be easily understood—regardless of the cost or benefit coverage. They can also receive a second opinion from our network of providers.
- Have timely access to their medical records in accordance with applicable state and federal laws. They may be required to sign for release of those records.
- Not to be balance billed by any provider for covered services other than the patient pay established by DSS toward LTSS services.
- Not to be discriminated against due to: medical conditions, including physical and mental illness; claims experience; receipt of healthcare; and medical history.
- Not to be treated against their will.
- Participate with their doctor in making decisions about their healthcare, give their consent for all care, and make decisions to accept or refuse medical care to the extent permitted by law and be made aware of the medical consequences of such action.
- Provide language assistance services, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as auxiliary aids, free of charge to members and/or the member's representative.
- Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand.
- To use advance directives (such as a "Living Will" or a "Power of Attorney"). Provide information to members about advance directives and any changes made in state law as soon as possible but no later than 90 days after the effective date of change.
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other departments.
- Always carry their and/or their child's Sentara Health Plans member ID card with them.
- Choose their and/or their child's Sentara Health Plans PCP from the list of our doctors from the provider directory.
- Work with their PCP to help establish a proper patient-physician relationship.
- Follow plans and instructions for care given by their physician.
- Get their healthcare from a participating PCP, hospital, or other healthcare provider.
- Give their PCP and other providers honest and complete information they need about the member's health to care for them.

Member Rights (continued)

- Inform their PCP of visits to other doctors so that they can be kept informed about the care that the member is receiving.
- Inform Sentara Health Plans if they have other health insurance coverage.
- Keep their doctor's appointments, or call to cancel them at least 24 hours ahead of the appointment time.
- Learn the difference between emergency and urgent care. Know what is considered an emergency, what to do if an emergency happens, and how to keep one from happening. Let Sentara Health Plans know if they have any problems, concerns, or suggestions on how we can work better for them.
- Take into advisement the recommendations of the care managers and other healthcare professionals at Sentara Health Plans.
- Tell the doctor that they are a member of Sentara Health Plans at the time that they speak with their doctor's office.
- Understand their health problems and discuss/agree upon a treatment plan with their physician.

Health Plan Commitments

1. **Program Information:** The health plan will provide a provider manual—accessible online—containing current information concerning policies and procedures. The health plan agrees to update as changes in requirements are made by law or otherwise.
2. **Provider Education:** The health plan communicates important updates and other information through various methods, including but not limited to quarterly newsletters, webinars, and email announcements. The purpose of these communications is to convey best practices so you can do business with us successfully.
3. **Provider Network:** Sentara Health Plans, Inc. will include the provider in the General Network of Participating Providers.
4. **Member Eligibility Verification:** Sentara Health Plans, Inc. agrees to provide a mechanism that allows providers to verify member eligibility before rendering services, based on current information held by Sentara Health Plans, Inc.
5. **Prior Authorization:** Request forms, policies, and procedures will be made available on our website.
6. **Timely Notification:** Provide notice of policy and procedure changes with no fewer than 60 days prior notice.

Provider Commitments

- **Provide Services:** Provide covered doula services to Sentara Health Plans members.
- **Maintenance of Credentials:** Maintain and submit to Sentara Health Plans, upon request, evidence of licensure, accreditation, registration, certification, and all other credentials sufficient to meet all applicable federal and state laws and regulations.
- **Provider Locations:** Provide covered services only at locations permitted under contract.
- **Notifications:** Give prior written notice to Sentara Health Plans as soon as possible, but at least 90 days before any change to the information about the provider included in the provider network directory.
- **Compliance With Sentara Health Plans, Inc. and Payor Programs, Policies, and Procedures:** Provider complies fully with all programs, policies, and procedures, as applicable.
- **Waiver of Copayments, Coinsurance, and Deductibles:** Collects all applicable coinsurance, copayments, and deductibles from members, and shall not waive the collection of such coinsurance, copayments, and deductibles without the written consent of Sentara Health Plans, Inc.
- **Noncovered Services:** Provider agrees not to bill, charge, or seek compensation or reimbursement of any kind from any member, Sentara Health Plans, Inc., or any payor for healthcare services and/or supplies provided determined not medically necessary or covered services.
- **Access to and Inspection of Records:** Upon reasonable notice—and during regular business hours—provide access by the health plan or its designee to inspect, audit, review, and make copies of records related to covered services rendered to Sentara Health Plans members.

Billing While Credentialing Is Pending

According to VA Law § 38.2-3407.10:1 of the Code of Virginia, Sentara Health Plans may reimburse providers for services while their credentialing application is pending. An application is considered pending once the application has been deemed complete/clean by Sentara Health Plans to advance within the credentialing process. Reimbursement for services rendered during the pending application period is contingent upon approval of the provider's credentialing application by the Sentara Health Plans Credentialing Committee.

New provider applicants, in order to submit claims to Sentara Health Plans pursuant to the law, shall provide written or electronic notice to covered members in advance of treatment that they have submitted a credentialing application to Sentara Health Plans stating it is in the process of obtaining approval. It is recommended that your notice includes the following information:

Notice of Provider Credentialing and Re-credentialing

Your health insurance carrier is required to establish and maintain a comprehensive credentialing verification program to ensure that its physicians, mental health professionals, and other providers meet the minimum standards of professional licensure or certification.

Written supporting documentation for (i) physicians, (ii) mental health professionals who have completed their residency or fellowship requirements for their specialty area more than 12 months prior to the credentialing decision, or (iii) other providers shall include:

- current valid license and history of licensure or certification
- status of hospital privileges, if applicable
- valid U.S. Drug Enforcement Administration certificate, if applicable
- information from the National Practitioner Data Bank, as available
- education and training, including postgraduate training, if applicable
- specialty board certification status, if applicable
- practice or work history covering at least the past five years
- current, adequate malpractice insurance and malpractice history covering at least the past five years

Your health insurance carrier is in the process of obtaining and verifying the above information in order to determine if your physician, mental health professional, or other provider will be credentialed or not.

H. The provisions of this section shall not apply to coverages issued by a Medicare Advantage plan, but shall apply to health maintenance organizations that issue coverage pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid).

Appointment Access Standards–Medicaid

Service	Sentara Health Plans Medicaid Standard
Emergency appointments, including Crisis Services	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request.
Urgent/Symptomatic appointments	Must be available as soon as the symptom demands but in no event more than 24 hours of the member's request. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring care in an emergency room setting.
Routine Primary Care	Routine, primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.).
Maternity Care – First Trimester	Within 7 calendar days of request
Maternity Care – Second Trimester	Within 7 calendar days of request
Maternity Care – Third Trimester	Within 3 business days of requests
Maternity Care – High-risk Pregnancy	Within 3 business days of high-risk identification, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery
Mental Health Services	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria is met.
LTSS	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria is met.

Appointment Access Standards–Commercial

Service	Sentara Health Plans Commercial Standard
Emergency appointments, including Crisis Services	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request.
Urgent appointments	Within 24 hours of the member's request
Routine Primary Care	Routine, primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.).
Maternity Care – First Trimester	Within 7 calendar days of request
Maternity Care – Second Trimester	Within 7 calendar days of request
Maternity Care – Third Trimester	Within 3 business days of requests
Maternity Care – High-risk Pregnancy	Within 3 business days of high-risk identification, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery
Mental Health Services	Appointment availability must be no more restrictive than for medical conditions.
LTSS	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria is met.

Appointment Access Standards–Medicare

Service	Sentara Health Plans Medicare Standards
Urgently needed services or emergency	Immediately
Services that are not emergency or urgently needed, but the member requires medical attention	Within 7 business days
Routine and preventive care	Within 30 business days

Managing Care Gaps

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

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

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

Provider Training Requirements and Recommendations

Required Annually

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

Encouraged

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

Resources for EPSDT Providers

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

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

Model of Care

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

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

Fraud, Waste, and Abuse (FWA)

Detecting FWA

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

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

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

Reporting Abuse

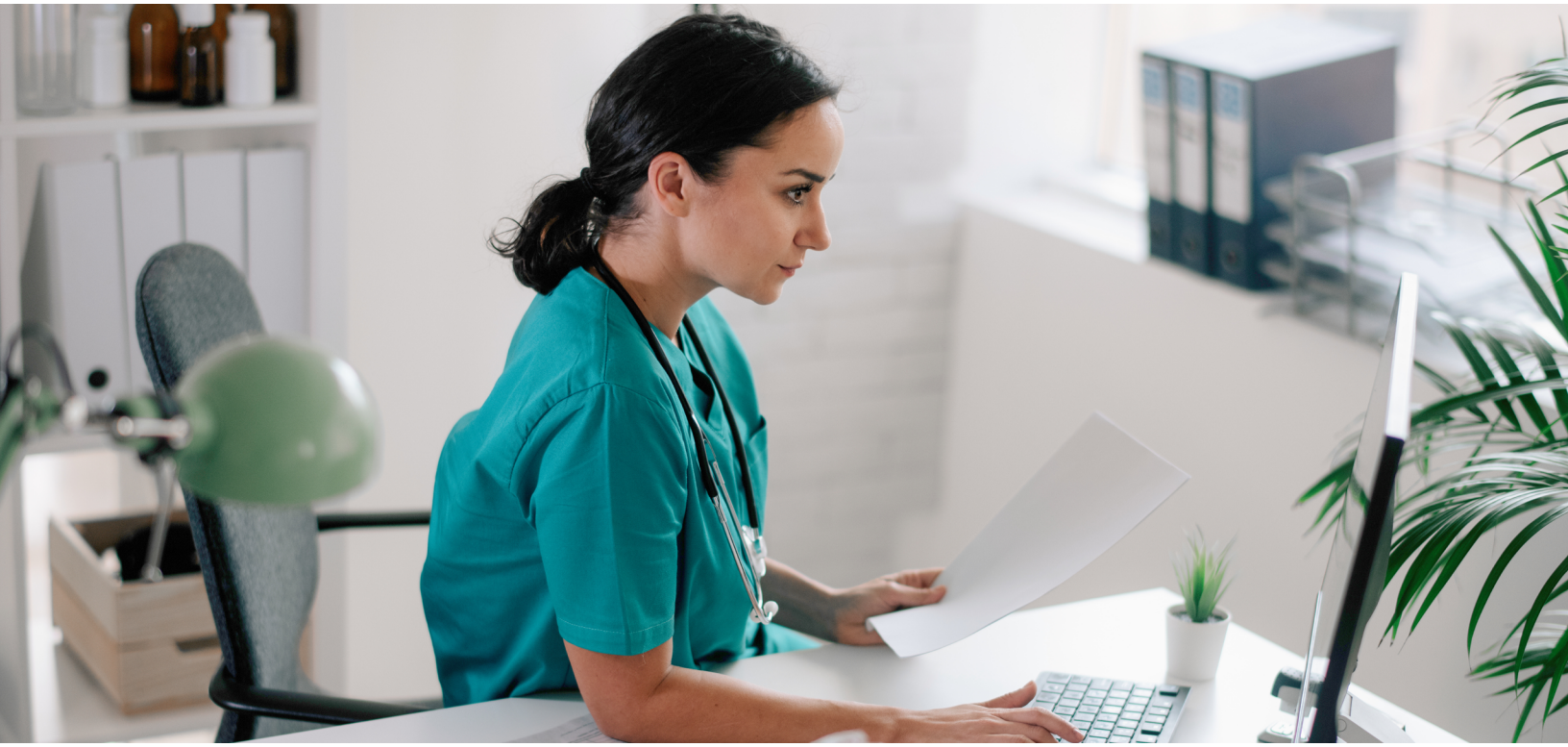
- Hotline: **1-866-826-5277**
- Email: **compliancealert@sentara.com**
- U.S. Mail:
  Sentara Health Plans C/O Special Investigations
  PO Box 66189
  Virginia Beach, VA 23466
- Refer to **provider manual** for more detail on this subject.

Accurate Coding and Billing

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

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

Member Identification



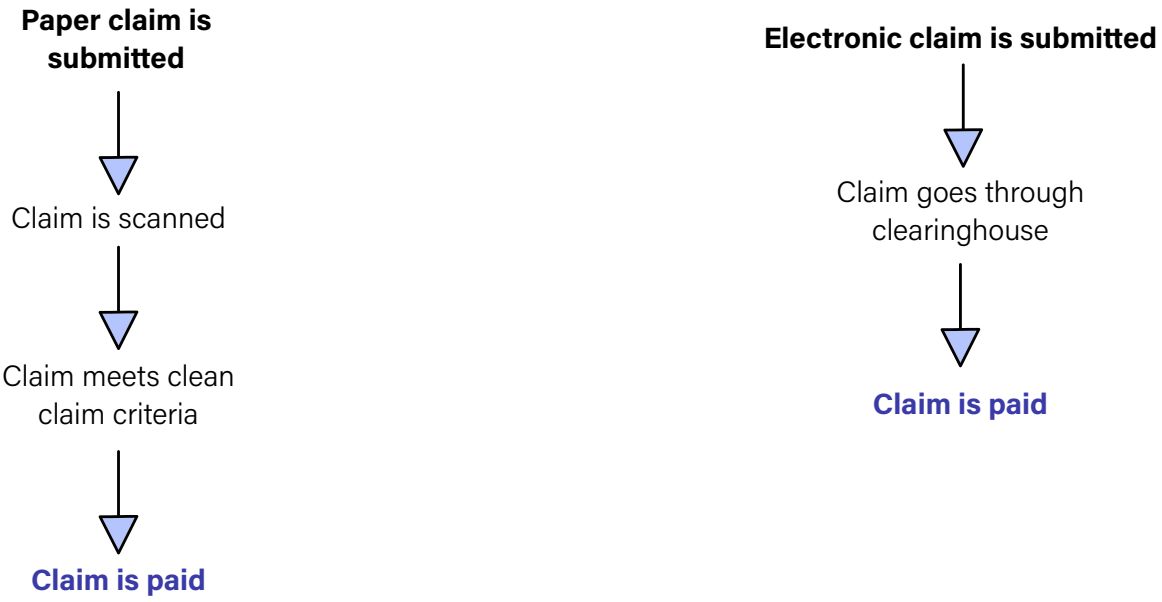
Billing and Claims

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

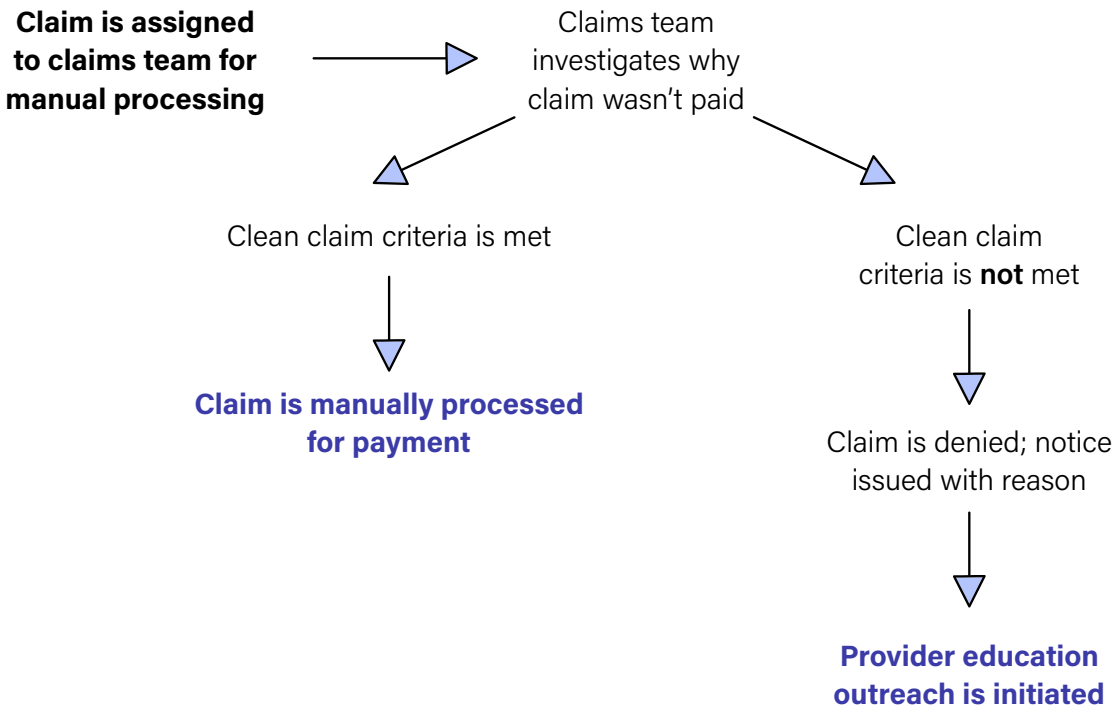
Critical Elements of Compensation and Billing:

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

Clean Claim/Auto Adjudication:



Clean Claim Criteria Not Met:



Common Reasons for Denial of Payment

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

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

Completing Paper Claims

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

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

Paper claims must be mailed to:

Medical Claims
PO Box 8203
Kingston, NY 12402-8203

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

Filing Claims Electronically

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

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

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

Remittance Advice

Medicare and Medicaid

All Medicare and Medicaid products will be processed on a single remit, and an active PaySpan account will be required.

New Payspan Users – How To Register:

To start the Payspan registration process, you may contact **providersupport@payspan.com** or call **1-877-331-7154**, option 1 to obtain the registration codes and assistance with navigating the website. Payspan is available Monday–Friday, 8 a.m.–8 p.m.

Learn More

For Current Payspan Users:

If providers already have an account, there will be a single registration code that is tied to the entry payment. If there are multiple pay to entries in Sentara Health Plans' claims platforms, providers will have multiple registration codes. To obtain codes, providers can contact Payspan and provide taxpayer identification numbers (TINs)/National Provider Identifiers (NPIs). If there are any questions, please contact a Payspan provider service representative at **1-877-331-7154**. Please see this **video link** to learn more about Payspan.

Note: *Providers are required to register with Payspan if they do not have an active account. Providers with active accounts that attempt to register again will receive the message, "There is no registration code available." If this occurs, the provider must contact Payspan directly at* **providersupport@payspan.com**.

Commercial and Self-funded

1. Complete the electronic funds transfer (EFT) and electronic remittance advice (ERA) Authorization Agreement PDF form it its entirety.
2. Obtain a letter from your bank. Ensure the letterhead includes the physi1cal bank address; account number; and the bank employee's name, title, email, and phone number. Letters must not be dated more than 90 days prior.
3. Form must be signed by the provider or an authorized representative of the provider.
4. Submit all documents by email to **EFT_ERA_Inquiry@sentara.com** or fax to **757-252-8037**.
5. Sentara Health Plans will validate the provider's relationship with the banking institution.
6. Tax ID information will be validated in the payment system.
7. Once the process is complete, the EFT information will be input into the payment system and the provider will be notified that the setup has been completed.

Visit our **website** for more information.

Reconsiderations and Appeals—MCO and FFS

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

Appeal Process

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

Mail to:

Medicaid/Medicare

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

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

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

Commercial

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

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

Refund Process

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

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

Obtaining an Authorization

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

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

Elective Admissions

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

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

Failure To Obtain Authorization

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

Urgent Authorization Requests

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

Vendor-facilitated Services

- **American Specialty Health Network (ASHN)**: chiropractor network claims are paid through ASHN; commercial and Medicare only; **1-800-848-3555**
- **DentaQuest:** dental network; commercial and Medicare; Medicaid is handled by DMAS directly; **1-888-278-7310**
- **Modivcare:** transportation vendor for Medicare, Medicaid, and commercial
- **Epic Hearing:** discounted service for hearing aids; commercial; **1-866-956-5400**
- **MDLive**: virtual visits; commercial, Medicare, and Medicaid
- **Nations Hearing:** discounted services for Medicare and Medicaid
- **Vision Services Plan (VSP):** routine vision care; only commercial, Medicare, and Medicaid
- **Community Eye Care (CEC):** a subsidiary of VSP will service all Medicare
- **LabCorp:** commercial, Medicare, and Medicaid
- **Quest Diagnostics:** commercial, Medicare, and Medicaid

Record Documentation Standards

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

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

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

Medical Records

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

- Active problem list must be current and 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 nor history of adverse reactions, these are appropriately noted in the record. A sticker or stamp noting allergies/no known allergies (NKA) on the cover of the medical record is acceptable.
- Past medical history—for patients seen three or more times—must be easily identified and include family history, serious accidents, operations, and illnesses. For children and adolescents 18 years and younger, past medical history relates to prenatal care, birth, operations, immunizations, and childhood illness.
- Each page of the medical record is to contain patient name or ID number. All entries are dated. Working diagnoses and treatment plans are consistent with medical findings.
- All requested consults must have return reports from the requested consultant, or a phone call follow-up must be noted by the PCP in the progress note. Any further follow-up needed, or altered treatment plans, should be included in progress notes. Consults filed in the chart must be initialed by the PCP to signify review. Consults submitted electronically must show representation of PCP review.
- Continuity and coordination of care among all providers involved in an episode of care—including PCP and specialty physicians, hospitals, home health, skilled nursing facilities, free-standing surgical centers, etc.,—must be documented when applicable.
- There should be documentation present in the records of all adult patients (emancipated minors included) that advance directives have been discussed. If the patient does have an advance directive, it should be noted and a copy included in the medical record.
- Confidentiality of clinical information relevant to the patient under review is contained in the record or in a secure computer system—stored in and accessible from a nonpublic area—and available upon identification by an approved person. All office staff must comply with HIPAA privacy practices.
- An assessment of smoking, alcohol, or substance abuse should be documented in the record for patients 12 years old and older. Referrals to a behavioral health specialist should be documented as appropriate.
- Records should indicate that preventive screening services are offered in accordance with our Preventive Health Guidelines. This should be documented in the progress notes for adults 21 years and older.

Behavioral Health Records

Medical records may be audited according to Sentara Behavioral Health Treatment Record Documentation Guidelines, which 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

Evidence of continuity of care involves the documentation of collaboration with the member's PCP regarding medication and treatment rendered, or documentation of the member's refusal to consent to the 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, adjustments in medication, and termination of treatment.

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

Reporting Critical Incidents

Reporting critical incidents:

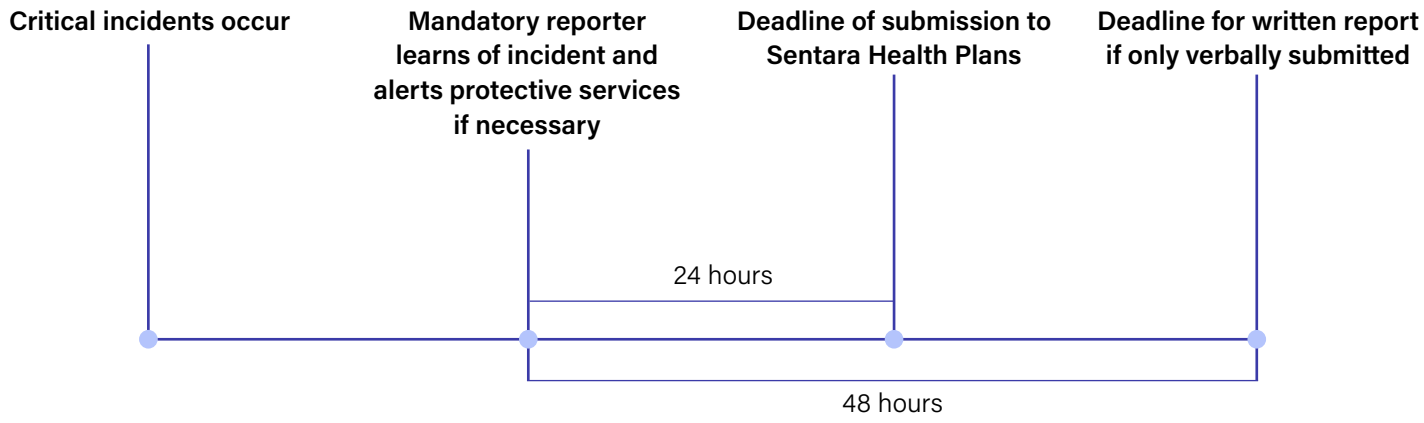
- ensures member/patient safety
- avoids repeatable errors
- addresses areas of concern
- complies with regulatory reporting requirements

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

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

Reporting Timeline

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



Resources

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

Definitions

1. **Billed Charge:** the actual amount charged by provider for any covered service furnished to a member.
2. **Clean Claim:** a claim that has no material defect (including any lack of required documentation).
3. **Covered Services:** those services, drugs, supplies, and equipment for which coverage benefits are available under the healthcare plans. Covered services beneficiaries are given benefits according to the terms and conditions of the health plan.
4. **Copayment:** charges for covered services collected directly by provider from member as payment, in addition to the fees paid to provider by the health plan.
5. **Deductible:** a dollar amount which a member is responsible to pay before the covered service.
6. **Electronic Health Record (EHR):** an electronic record of clinical services rendered by a participating provider to a member.
7. **Fee Schedule:** a list of the maximum amounts allowed per unit for covered services.
8. **Medically Necessary:** those covered services as provided by a participating provider which are:
   - required to identify, evaluate, or treat the member's condition, disease, ailment, or injury—including pregnancy-related conditions
   - in accordance with recognized standards of care for the member's condition, disease, ailment, or injury
   - appropriate regarding standards of good medical practice
   - not solely for the convenience of the member or a participating provider
   - the most appropriate supply or level of service which can be safely provided to the member
9. **Noncovered Services:** those healthcare services that are not covered services.
10. **Provider Network:** a group of participating providers that, through a contractual relationship, supports some or all products in which members are enrolled.
11. **Quality Improvement or Utilization Management:** the processes established and operated by the health plan, or its designee, to evaluate and promote the quality and cost-effective delivery of covered services.
12. **Clean/Complete Application:** provider meets eligibility criteria for Sentara Health Plans credentialing, and application submission includes all provider information and documentation required for Sentara Health Plans to proceed with the credentialing process. Clean/complete status is determined by the Sentara Health Plans Credentialing Department upon initial application review.
13. **Taxonomy:** a unique 10-character code that designates a healthcare provider's classification and specialization.

Helpful Resources

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

Sentara Health Plans Provider Manual

DMAS Provider Manuals

EPSDT Supplement B

MES Provider Portal

Sentara Health Plans Quick Reference Resources:

- Clinical references
- Authorizations

E-booklets:

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