Medicare Dual-Eligible Special Needs (D-SNP) Provider Manual

Medical and Behavioral Health Provider, Facility, and Ancillary

A Publication of Sentara Health Plans' Network Management Department.

This version of the Sentara Health Plans Provider Manual was last updated on April 8th, 2026.

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

This version of the Medicare Dual-Eligible Special Needs Provider Manual supersedes previous versions. The requirements and obligations in this Manual apply to services rendered from April 8th, 2026, until Sentara Health Plans publishes an updated version.

Sentara® Health Plans

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Introduction and Welcome

Welcome to Sentara Health Plans. Participating providers are an integral member of our team. Thank you for making it possible for Sentara Health Plans to promote the maintenance of health and the management of illness and disease by providing access to quality healthcare to the communities we serve.

Easily find information in this Provider Manual using the following steps: Select CTRL+F. Type in the keyword(s). Press Enter.

This Provider Manual covers policies and procedures for providers for Dual-Eligible Special Needs Plans (HMO D-SNP) administered by Sentara Health Plans.

Providers should refer to the Sentara Health Plans Medicaid Program Provider Manual for Medicaid program information and to the Sentara Health Plans Commercial Provider Manual for specific information about commercial plans. Both Provider Manuals are available on the Sentara Health Plans provider website.

Within this manual, providers will find important information to assist with member and product identification, authorizations, claims reimbursement policies/procedures, and provider obligations under the Provider Agreement. Providers will also find useful information such as key contact information and direct weblinks to policies and forms. Additional information and tools are available at **sentarahealthplans.com**.

The Provider Manual was developed to assist providers in understanding the administrative requirements associated with managing members' healthcare. The Provider Manual, including all sources that are referenced by and incorporated herein, via weblink or otherwise, is a binding extension of the Provider Agreement and is amended as our operational policies or regulatory requirements change. In addition to the Provider Manual being available online, it is also available in printed form by written request. Many of the policies and procedures that are referenced by or incorporated into this Provider Manual are available on the provider website. Providers are responsible for complying with updates to the Provider Manual, as they are made available from time to time. Sentara Health Plans notifies providers of updates to this manual via email and website notification 60 days in advance of operational changes that could impact providers doing business with Sentara Health Plans.

If there is a conflict between this Provider Manual and any state law, federal law, or regulatory requirement and this Provider Manual, the law or regulation takes precedence.

Should this Provider Manual conflict with the Provider Agreement, the Provider Agreement takes precedence.

As a provider for our Medicare Full Dual and Partial Dual Plans, you are responsible for adhering to requirements and regulations from this Provider Manual, the Sentara Medicaid Program Provider Manual, the Provider Agreement, and the state and federal governments.

The following terms are used throughout this Provider Manual:

Affiliate means any entity (a) that is owned or controlled, directly or indirectly, through a parent or subsidiary entity, by Sentara Health Plans, or any entity which is controlled by or under common control with Sentara Health Plans, and (b) which Sentara Health Plans has agreed may access services under the Provider Agreement.

Clean Claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Provider Agreement means the participating provider agreement, attachments, and any amendments.

Member means any individual, whether referred to as “member,” “participant,” “enrollee,” or otherwise, who is enrolled in Medicare and Medicaid and then enrolls in a D-SNP plan.

Participating Provider whether referred to as “provider” or otherwise, means a duly licensed physician or other health and/or mental healthcare professional, as designated at the sole discretion of Sentara Health Plans, who has entered into a contract with Sentara Health Plans or any of its affiliates either as an individual or as a member of a group practice and who has been approved to provide covered services under a health benefit plan(s) in accordance with Sentara Health Plans’ credentialing requirements and the requirements of such contract between the provider and Sentara Health Plans (or the Affiliate) at the time such covered services are rendered. Participating providers include, but are not limited to, licensed professional counselors, marriage and family therapists, board-certified behavioral analysts, nurse midwives, nurse practitioners, certified registered nurse anesthetists (CRNAs), physician assistants, participating hospitals, and other licensed health or mental healthcare professionals, as designated by Sentara Health Plans, in its sole discretion.

Practitioner means the medical professional that is either employed by or has executed an agreement with Sentara Health Plans, or its subcontractor, to render covered services to Sentara Health Plans members.

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Sentara Health Plans Key Contact Information

Provider and Member Services

Provider Services
Phone: **1-800-229-8822**
Fax: **1-757-552-7316**

D-SNP Member Services
Phone: **1-866-650-1274**

Behavioral Health Provider Services
Phone: **1-800-648-8420**
Fax: **1-844-348-3719**

Medicare Pharmacy Provider Services
Phone: **1-800-229-8822**

Clinical Care Services

Medical Authorizations and Medical Benefit Drugs for Sentara Health Plans Medicare
Phone: **1-888-946-1167**

Authorizations Behavioral Health Providers
Phone: **1-800-229-8822**

Behavioral Health Crisis Line
For a psychological medical emergency, please call 9-8-8, the National Suicide & Crisis Lifeline, or go to the nearest emergency room.

Quality Improvement
Phone: **1-844-620-1015**
Fax: **1-804-799-5102**

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

Health and Preventive Services
Phone: **1-833-477-5464**
Email: **wellness@sentara.com**

Fraud and Abuse

Hotline: **1-866-826-5277**
Email: **compliancealert@sentara.com**
U.S. Mail: **Sentara Health Plans**
Program Integrity Department
1330 Sentara Park, Virginia Beach, VA 23464

Claim Payment Reconsiderations

Mail:

Medical Claims

PO Box 8203
Kingston, NY 12402-8203

Behavioral Health Claims

PO Box 8204
Kingston, NY 12402-8204

Overpayments

Phone: **1-800-229-8822**
Mail: **Sentara Health Plans Provider Receivables**
PO Box 66189
Virginia Beach, VA 23466

Network Management

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

Appeals and Grievances

Medicare Member Services Phone: **1-800-927-6048**
Fax: **1-800-289-4970**

Mail: **Sentara Health Plans**
Medicare Appeals and Grievances
PO Box 62876
Virginia Beach, VA 23466

In-Person Delivery: **1300 Sentara Park, Virginia Beach, VA 23464**

Medicare Appeals Email: **MedicareAppeals@sentara.com**
Medicare Grievance Email: **Medicare_Griev@sentara.com**

Product Overview

Sentara Health Plans offers two Medicare Dual-Eligible Special Needs Plans (HMO D-SNP):

- Sentara Community Complete – A fully integrated dual eligible special needs plan (FIDE SNP)

- Sentara Community Complete Select – A partial dual eligible special needs plan (PDSNP)

Our plans provide Medicare Part A, B, and D benefits for members who are also eligible for full or partial Medicaid benefits. Special needs plans allow monthly enrollment throughout the year. Members must apply by the last day of the month for their coverage to begin the first of the following month.

Among the most important features of the D-SNP are:

- A team of doctors, specialists, and care managers working together for the D-SNP member
- A Model of Care (MOC) that calls for individual care plans and management for all plan members
- Medicare and Medicaid Rights and Responsibilities are available to all member recipients

Full benefit dual eligible Medicaid enrollees who have elected to enroll in a type of Medicare Advantage (MA) Plan called a Dual Eligible Special Needs Plan (D-SNP) will be assigned to the same health plan for their Medicaid managed care as they selected for their D-SNP.

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

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

There are numerous benefits to an aligned enrollment. For Sentara members, Sentara Medicare will coordinate coverage of both the member's Medicare and Medicaid benefits through Sentara Health Plans, streamlining administrative processes for providers and meeting the member's need for coordinated, comprehensive care. Sentara Community Complete and Sentara Community Complete Select are available statewide in Virginia.

In addition to standard Medicare coverage, Sentara Medicare D-SNP members also qualify for

additional supplemental services. Please refer to the Benefit Information section for those services.

Providers submit claims directly to Sentara Community Complete. Sentara Medicare coordinates payment to the provider from Medicare and Medicaid. Sentara Community Complete members have Medicare cost-sharing protection under their Medicaid benefits. Providers may not bill members for the balance of any service rendered, nor bill them for services not reimbursed by Sentara Community Complete. Members may have copayment requirements for prescription drugs covered under Medicare Part D.

Dual-Eligible Members with Both Medicare and Medicaid
If services are provided to a member who is eligible for both Medicare and Medicaid, then the provider may not bill or hold liable the dual-eligible member for Medicare Parts A and B cost sharing if Medicaid is liable for such cost sharing. Sentara Health Plans will coordinate the claim processing for primary and secondary; therefore, no secondary claim submission is required for payment. This includes claims for Medicaid only benefits as well.

Services being billed	Primary insurance	Billing instructions
Medicaid Program Waiver Only (Medicare Non-Covered Services)	Sentara Health Plans D-SNP	Bill directly to Sentara Health Plans.
	Medicare fee-for-service	
	Other TPL Coverage	
	Sentara Health Plans D-SNP	Submit one claim directly to Sentara Health Plans, which will process both the Medicare and Medicaid portions of the claim. No additional claim submission for secondary claims is required.
All Other Services	Other TPL Coverage	Bill directly to the primary insurance. Upon receiving the final determination (Remit/EOB) from the primary payer, submit a secondary claim to Sentara Health Plans.
	Medicare fee-for-service	Bill directly to CMS. Under the Coordination of Benefit Agreement (COBA), CMS will submit the crossover claim directly to Sentara Health Plans. No claim submission for secondary claims is required.

Member Identification

Member ID Cards

D-SNP members will have one identification card, which will reflect their D-SNP coverage and include their Medicaid identification number. Providers should utilize one identification card to verify benefits for both the Medicare and Medicaid plans for these dual-eligible members.

Providers may identify eligible Sentara Medicare D-SNP members through multiple means, including:

- Sentara Medicare D-SNP member ID card – example provided here
- Availity provider portal via the Eligibility and Benefit search
- Sentara Community Complete Member Services – 1-866-650-1274 (TTY: 711)
- Evidence of benefits statements (EOBs)

Eligibility – Sentara Community Complete (HMO D-SNP)

In general, individuals are eligible for Virginia D-SNP if they are eligible for Medicare Parts A, B, and D, and are also fully eligible for Medicaid. Examples of Virginia residents who are eligible for Sentara Community Complete are listed below. However, some exclusions apply.

- **Qualified Medicare Beneficiary Plus (QMB+):** an individual entitled to Medicare whose income is equal to or less than 100 percent of the federal poverty level (FPL) and who is determined eligible for full Medicaid coverage.
- **Special Low-Income Medicare Beneficiary Plus (SLMB+):** an individual entitled to Medicare whose income falls between 100 percent and 120 percent of the FPL and who also meets the financial criteria for full Medicaid coverage.
- **Other Full-Benefit Dual Eligible (FBDE):** an individual entitled to Medicare, who does not meet the income or resource criteria for QMB+ or SLMB+, but who is eligible for full Medicaid coverage either categorically or through optional coverage groups based on medically needy status, special income levels for institutionalized individuals, or home and community-based waivers.

Eligibility – Sentara Community Complete Select (HMO D-SNP)

- **Qualified Medicare Beneficiary without other Medicaid (QMB only):** an individual entitled to Medicare whose income is up to 100 percent of the federal poverty level (FPL) and who is determined eligible for partial Medicaid coverage.

Medicare population categories for which DMAS only pays a limited amount each month toward their cost of care are not eligible for D-SNP plans. Those categories include, but are not limited to, Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), and Qualifying Individuals (QIs).

Eligibility Verification

Since a member's eligibility status may change, member coverage should be verified at the time of service. Providers may access the Availity provider portal or call the Sentara Health Plans interactive voice response (IVR) system 24 hours a day, 7 days a week for the most current

eligibility in Sentara Health Plans systems. Sentara Health Plans verifies coverage based on the most current data available from DMAS. Retroactive changes could alter the member's status; therefore, verification of eligibility **is not** a guarantee of payment.

Joining the Network, Credentialing, and Provider Directory Processes

Provider Participation Requirements

Medicare Advantage and Medicaid program providers contracted with Sentara Medicare are included in the Sentara Community Complete and Sentara Community Complete Select network unless they have opted out of D-SNP.

In addition to the requirements defined in the Sentara Medicaid Program Provider Manual, Sentara Community Complete and Sentara Community Complete Select providers must agree to the prohibition on billing members for Medicare Part A and B deductibles, premiums, and copayments. Sentara Community Complete and Sentara Community Complete Select members are protected from all cost sharing for Medicare Part A/B and Medicaid services. Members who are not institutionalized or receiving care under a home and community-based services waiver may be responsible for Part D copayments for prescription drugs.

Join the Network

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

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

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

Credentialing Overview

The information below is a summary of the standard Sentara Health Plans credentialing process. The goals of the Sentara Health Plans credentialing/recredentialing policy are to ensure quality care and patient safety by utilizing credentialing and recredentialing standards outlined by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), Sentara Health Plans policies, and applicable state regulations. Sentara Health Plans will review the education, experience, and credentials of all practitioners who care for Sentara Health Plans members at the time of their initial request to participate in the network (credentialing). Sentara Health Plans will, at a minimum, recredential all providers every 36 months thereafter. Sentara Health Plans may elect to recredential providers after shorter time intervals based on the medical director's or credentialing committee's requests. No provider will be included in the Sentara Health Plans network without being credentialed. All providers must maintain current recredentialing status and continue to meet all Sentara Health Plans accreditation requirements as well as state, and federal regulations between credentialing cycles during ongoing monitoring. No practitioner will be denied or terminated from network participation based on their age, sex, race, ethnicity, religion, national origin, or disability.

Scope

Practitioners who require credentialing as a condition of participation with Sentara Health Plans are:

- Practitioners who are licensed, certified, or registered by the state to practice independently.
- Practitioners who have an independent relationship with Sentara Health Plans. An independent relationship exists when Sentara Health Plans directs its members to see a specific practitioner or group of practitioners, including all practitioners with whom members can select as Primary Care Practitioners (PCPs). An independent relationship is not synonymous with an independent contract. Sentara Health Plans does not credential some practitioners with whom it holds independent contracts. However, if a practitioner is listed in the Sentara Health Plans network directory, the practitioner must be credentialed.
- Practitioners may seek approval from Sentara Health Plans to participate as a PCP and a specialist providing they meet Sentara Health Plans' participation criteria for all scopes of practice being requested.
- Practitioners who see members outside the inpatient hospital setting or outside freestanding ambulatory facilities.
- Practitioners who are hospital-based but who also see Sentara Health Plans members as a result of an independent relationship with the Sentara Health Plans.
- Oral surgeons and dentists who provide care to Sentara Health Plans members under the members' medical benefits.
- Non-physician practitioners who have an independent relationship with Sentara Health Plans and who provide care to members under Sentara Health Plans' medical benefits.
- Telemedicine practitioners.
- Rental network practitioners that are part of Sentara Health Plans' primary network, and Sentara Health Plans has members who reside in the rental area.
- Rental network practitioners that are part of Sentara Health Plans out-of-area care, and members may see only those practitioners or are given an incentive to see the rental network practitioners; or
- PPO network practitioners, if information about the network is included in member materials or on a member ID Card that directs members to use the network, or there are incentives for members to see the PPO network practitioners.
- Locum Tenens practitioners who work fewer than 60 days or more than 60 calendar days.

Practitioners Who Do Not Need to be Credentialed

The following types of practitioners need not be credentialed:

- Practitioners who do not have an independent relationship with Sentara Health Plans, and meet any of the following:
- Practitioners who practice exclusively within the inpatient setting, and who provide care for Sentara Health Plans members only as a result of members being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within free-standing facilities and who provide care to Sentara Health Plans members only as a result of members being

directed to the facility.
- Pharmacists who work in conjunction with a pharmacy benefit management organization to which Sentara Health Plans delegates utilization management functions.
- Covering practitioners (e.g., Locum Tenens) who do not have an independent relationship with Sentara Health Plans.
- Practitioners who do not provide care for Sentara Health Plans members (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

Hospital-Based Practitioners (including, but not limited to):
- Anesthesiologists
- Emergency medicine practitioners
- Hospitalists/hospital medicine practitioners
- Pathologists
- Radiologists
- Neonatal/perinatal practitioners
- Critical care medicine practitioners
- Trauma medicine practitioners
- Certified registered nurse anesthetists
- Any other specialty practitioner practicing exclusively in an inpatient setting

Non-inpatient facilities in which practitioners may practice exclusively and provide care for members only as a result of members being directed to the facility may include, but are not limited to:
- Mammography centers and free-standing radiology centers
- Urgent care centers
- Surgery centers
- Ambulatory behavioral health facilities
- Psychiatric and substance use disorder clinics
- School-based clinics

School-based practitioners
- School nurses

Organizational Contracting Approval

Organizations that bill under a Type 2 National Provider Identifier (NPI) utilize the organizational credentialing policy and procedure.

Marriage and Family Therapists and Mental Health Counselors

Effective January 1, 2024, the Centers for Medicare & Medicaid Services (CMS) recognizes licensed Marriage and Family Therapists (MFT) and licensed Mental Health Counselors (MHC) as a new Medicare provider type. Payment for these services under Part B of the Medicare

program began on January 1, 2024. CMS defines MFT services as services furnished by an MFT for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MFT is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service. CMS defines MHC services as services furnished by a mental health counselor (MHC) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MHC is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service. For more information from CMS, please visit their **website**. Contact the behavioral health contract manager assigned to the practice to determine if the Provider Agreement needs to be amended.

Long-Term Services and Supports (LTSS) Credentialing

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

Sentara Health Plans ensures that HEOPS-Centipede credentials and re-credentials providers per DMAS and Medicaid program requirements and ensures that all providers comply with provisions of the CMS Home and Community-based Settings Rule.

Providers already contracted and credentialed with Sentara Health Plans for the provision of medical services that also provide LTSS services must also contract with Centipede/HEOPS for the provision of LTSS services to Medicaid program members.

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

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

Council for Affordable Quality Healthcare (CAQH)

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

Contact Information for CAQH

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

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

Supporting Documents

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

- Current state medical licenses
- Drug Enforcement Administration (DEA) certificate (as applicable)
- Current malpractice insurance face sheet indicating the amount of coverage:
    - For the Commonwealth of Virginia, providers must maintain coverage in amounts not less than the medical malpractice cap currently in effect under the Virginia Code (the "Code"). Medical Professional Liability (malpractice) insurance in the amount equal to, not less than, the limitation on recovery for certain medical malpractice actions specified in Section 8.01-581.15 of the Code of Virginia, as such Section may be hereafter amended or superseded (currently $2,700,000 per occurrence) and twice that amount (currently $5,400,000) annual aggregate. These limits change year to year, and it is advised that the provider review the Code annually, upon renewal of their policy, to ensure they have the correct limits applied to their current policy. In states other than Virginia, if the state does not require a minimum medical malpractice coverage, the provider must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year. Non-prescribing Sentara Health Plans behavioral health providers in Virginia, individual non-physician providers must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.
- Curriculum vitae (resume) that includes work history for the past five years

Where applicable, practitioners should also submit:

- A letter of explanation for any gaps in malpractice insurance.
- A letter of explanation for any gaps in work history of six months or longer in the past five years.
- A letter of explanation for practitioners who do not have an active DEA or Controlled Dangerous Substances (CDS)/Controlled Substance Registration CSR certificate, but who should have one based on their practice. Such practitioners must state the reason for not having a DEA or CDS/CSR certificate, and the appropriate covering Practitioner who will agree to write prescriptions for their members, if applicable.
- Evidence of patient coverage or transfer arrangements with another Plan participating Practitioner to manage their Plan membership hospitalizations; or have documented admission arrangements with a hospitalist group to a participating Plan hospital.
- Educational Commission for Foreign Medical Graduates (ECFMG) certificate if a foreign medical school graduate with an ECFMG number noted in CAQH.
- Cross coverage forms from the covering provider if not within the provider's practice.
- Explanations for malpractice cases.
- Explanations for license sanctions or license limitations.

Practitioners must have acceptable 24-hour coverage which includes arrangements for alternate care of patients when the Practitioner is unavailable through another qualified Practitioner consistent with the Plan's policies and procedures and standards and/or

criteria.

Credentialing Process

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

Verifications

The Sentara Health Plans credentialing department verifies with the primary source that the provider meets the Sentara Health Plans credentialing requirements. Any verifications performed that have an actual expiration date, such as a DEA or license, must be verified within 120 days of the credentialing or recredentialing decision, and the expiration dates must still be valid on the date the decision is made.

Providers are required to complete an application for initial credentialing and recredentialing. The applications must contain a current, signed, and dated attestation statement as to the correctness and completeness of the application. The Plan uses the Council for Affordable Quality Health Care's (CAQH) Universal Provider Data Source Application found at https://proview.caqh.org as part of our credentialing and recredentialing processes. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired, and the disability is documented in the practitioner's file. CAQH has a system that allows providers to update application information electronically. NCQA accepts the last attestation date generated by this system as the date when the provider signed and dated the application to attest to its completeness and correctness.

If the application and attestation must be updated, only the provider may attest to the update; Plan staff may not. If a copy of an application from an external entity to the Plan is used, it must include an attestation to the correctness and completeness of the application. NCQA does not consider the associated attestation elements present if the Practitioner did not sign the application within the required time frame.

The following verifications are completed for each participating provider:

- Review of the full application to ensure it is fully completed.
- Verification of current, valid state licensure (licenses will be verified for all states where the provider provides care to Sentara Health Plans members).
- Verification of current valid DEA/CDS/CSR (if applicable).
- Verification of education and training (if the provider is an individual practitioner).
  Sentara Health Plans verifies the highest of the following levels of education/training obtained by the provider (if the provider is an individual practitioner) as appropriate:
  - Board certification in their practicing specialty(ies).
  - Residency in their practicing specialty(ies).
  - Graduation from a medical or professional school.

Sentara Health Plans only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States, the American Osteopathic Association in the United States, the College of Family Physicians of Canada, and the Royal College of Physicians and Surgeons of Canada.

Note: Verification of Fellowship completion & any future program completion dates do not meet the requirement for verification of education and training.

- Board certification status

  Note: Verification of board certification does not apply to Nurse Practitioners, Physician Assistants, or other non-physician health care professionals unless the Plan communicates these board certifications to Plan members. Sentara Health Plans may, at its sole discretion, waive the specialty board certification requirement for applicants who meet a certain criterion, not limited to practicing with a specialty required to fill a geo-access gap in an underserved geographic area.

- Work history (minimum relevant work history of the most recent 5 years)

  Note: Provider must explain any gap(s) in work equal to or exceeding six months

- Current professional liability insurance that meets state limit requirements
- Five Practice-Year malpractice history
- Medicare and/or Medicaid sanction history
- State license sanctions or limitations
- Hospital privileges or acceptable coverage arrangements
- National Provider Identification (NPI)
- Federal sanction
- System for Award Management (SAM).
  - Medicare & Medicaid sanctions
  - Medicare & Medicaid exclusions

Specialty-Specific Credentialing Requirements

In addition to the general credentialing requirements applicable to all providers, additional requirements may apply to certain provider types in accordance with SHP policies and DMAS policies, provider manuals, regulations, and the contract between DMAS and Sentara Health Plans. Provider agrees to furnish information and documentation necessary for Sentara Health Plans to perform credentialing and recredentialing in accordance with such requirements.

A provider's credentialing or recredentialing file is deemed complete and ready for medical director or credentialing committee review when a complete application has been received, all supporting documents and/or responses have been received, and all verifications, primary source or otherwise, have been confirmed. Sentara Health Plans notifies providers within 30 days of receipt of the provider's credentialing application if such application is incomplete. Completed files are reviewed by the credentialing

department to ensure the provider's electronic file in Sentara Health Plans' credentialing system has been fully updated and all required tracking information, application, documents, and primary source verifications have been obtained and are stored appropriately. Completed files are then assigned a "clean" or "issue" status based on the criteria outlined in the credentialing policy and procedure. The Sentara Health Plans medical director has the authority to approve clean files. All "issue" files must be reviewed and determined by the credentialing committee.

Sentara Health Plans does not discriminate, in terms of participation, reimbursement, or otherwise against any health care professional or facility that is acting within the scope of their license or certification under state law, on the basis of the license or certification.

Sentara Health Plans does not make credentialing or recredentialing decisions based on a practitioner's race, ethnic or national identity, gender, age, sexual orientation, or the type of procedure(s) or patient (i.e., Medicaid and Medicare), in which the practitioner specializes. This does not preclude the Plan from including in its network practitioners or facilities who meet certain demographic or specialty needs, for example, the cultural needs of Sentara Health Plans members. Sentara Health Plans does not discriminate against practitioners or facilities that serve high-risk member populations or specialize in conditions that may require costly treatment.

Following credentialing or recredentialing decision determinations issued by the medical director or credentialing committee, a letter is sent to the provider advising them of the decision. Unless specific state notification time frames exist, the NCQA notification time frame of sending the decision notification letter within 30 calendar days of the approval or denial determination will be followed. In the event a denial decision is issued, the provider is notified in writing within 30 calendar days of the denial reason and, if applicable, offered the right to appeal.

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

Recredentialing

Sentara Health Plans recredentials all providers at least every 36 months. Information and documents are obtained and verified according to the credentialing policy and procedure standards. CMS and NCQA counts the 36-month cycle to the month, not to the day. The recredentialing process will also include performance-monitoring information on each provider. This review includes a review of adverse data from any of the following plan data areas:

- Member grievances and/or complaints
- Utilization management
- Quality improvement, performance quality measures, quality deficiencies, and/or trend patterns
- Site assessment and/or medical record keeping practice/treatment assessment issues

Confidentiality and Provider Rights

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

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

An applicant may review any documentation submitted by the applicant in support of their application, together with any information received from outside sources such as malpractice carriers, state licensing agencies, or certification boards. Providers may not review any peer review information obtained by Sentara Health Plans. Providers are informed of this Right through the Credentialing Program Description, which is posted publicly on Sentara Health Plans' website. Providers may choose to request a review of this information at any time by sending a written request to the Credentialing Department online at SHPCredDept@Sentara.com or through the United States Postal Service at:

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

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

Sentara Health Plans notifies the provider of any discrepancy it has received during the credentialing and recredentialing process within 30 days of receipt. Sentara Health Plans informs

the provider of the discrepancy and requests a written explanation be submitted within 10 days. Providers are provided with a copy of the discrepant information to review. The provider is asked to provide a written explanation of the correction within 10 business days of receipt. If a correction is needed to the provider's application, they are asked to make the correction on the application page(s) and to sign/date each correction made to the application. After Sentara Health Plans receives the corrected information, it will continue to process the provider's file and will follow Sentara Health Plans' normal review process for medical director or credentialing committee participation determination. The provider will be notified of the medical director or credentialing committee participation decision within 30 days of the determination date.

Ongoing monitoring

Sentara Health Plans monitors provider sanctions, grievances/complaints, and quality issues between credentialing cycles and will take action(s) against providers when it identifies occurrences of poor quality. Sentara Health Plans acts on important quality and safety issues promptly by reporting such occurrences to the Credentialing Committee or other designated peer-review body. If an occurrence requires urgent attention, the medical director and/or designee will address it immediately, and the Committee and/or the Medical Director may take any action(s) reasonably necessary to ensure quality. On an ongoing monitoring basis, Sentara Health Plans collects and takes intervention and/or action by:

- **Collecting and reviewing Medicare and Medicaid sanctions and exclusions**
  Sentara Health Plans will review sanction and exclusion information from the OIG and CMS Preclusion list and a NCQA-approved source at least monthly or within 30 calendar days of a new alert.
- **Collecting and reviewing sanctions or limitations on licensure**
  Sentara Health Plans will review sanctions and limitations on licensure in all states where the practitioner or facility provides care to Plan members. Licensure sanction and limitation monitoring will be reviewed from a CMS and a NCQA-approved source at least monthly or within 30 calendar days of a new alert.
- **Collecting and reviewing grievances/complaints**
  Sentara Health Plans investigates all practitioner-specific member complaints upon receipt and evaluates the practitioner's history of complaints. Additionally, evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a trend is identified, a level rating will be assigned. The Credentialing Committee or other designated peer-review body will recommend appropriate interventions based on assigned scoring. When the appropriate interventions are determined, the provider will follow the recommendations to address the issues that were identified, including quality and safety concerns.
- **Collecting and reviewing information from identified adverse events**
  Sentara Health Plans monitors adverse events at least monthly to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the adverse event, Sentara Health Plans will implement actions and/or interventions based on its policies and procedures when instances of poor quality are identified.

Credentialing for Facility and Ancillary Providers

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

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

- Reassess the credentials of each participating organizational provider at least every 36 months after initial credentialing.
- Confirm that the provider is in good standing with state and federal regulatory bodies.
- Confirm, when applicable based on provider type, that the provider has been reviewed and approved by an acceptable accrediting body.
- Conduct a quality assessment of the organization when organizational providers are not accredited.
- Review a copy of a quality review by the Centers for Medicare and Medicaid (CMS) or applicable State review board in lieu of Sentara Health Plans conducting its own quality assessment if the CMS or state assessment is no more than 3 years old. If the CMS or State assessment is older than 3 years, Sentara Health Plans is required to perform its own quality assessment.

  Note: Sentara Health Plans is not required to conduct a quality assessment if the organizational provider is located in a rural area, as defined by the U.S. Census Bureau at https://www.hrsa.gov/ruralhealth/about-us/definition/datafiles.html, and the State or CMS has not conducted a site review.

- Confirm proof of general and professional liability insurance. At least $1 million per occurrence and $3 million in the aggregate is required.
- Validate an active National Provider Identifier (NPI).
- Validate licensure, if applicable.
- Validate the absence of Medicare or Medicaid sanctions and federal exclusions.

Facilities and ancillaries must provide Sentara Health Plans with copies of current accreditation certificates (if applicable), or Medicare certification survey results, general and professional liability insurance, and State licensures, as applicable to each contracted facility or ancillary. In addition, completion of a Disclosure of Ownership and Control Interest Statement is required.

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

Disclosure of Ownership and Control and Control Interest Statement

Sentara Health Plans requires all provider-disclosing entities to complete a Disclosure of Ownership and Control Interest Statement at initial contracting/credentialing and at recredentialing as a condition of participation. Ownership means a direct or indirect ownership interest totaling 5% or more. Disclosure as a participating fee-for-service provider for DMAS meets this requirement for Sentara Health Plans.

Notice of Suspension Requirement

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

Accreditations and Certifications

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

Accrediting Body	Acronym	Examples of Organizational Provider Types Accredited
Accreditation Association for Ambulatory Health Care	AAAHC	Hospitals, Surgery Centers, FQHC, Imaging Center, Urgent Care
Accreditation Commission for Health Care, Inc. (formerly HFAP)	ACHC	Hospitals, Surgery Centers, Behavioral Health, Assisted Living
American Academy of Sleep Medicine	AASM	Sleep Laboratory, DME
American Association for Accreditation of Ambulatory Surgery Facilities	AAASF	Surgery Centers, Rural Health Centers, Physical Therapy Centers
American Association for Laboratory Accreditation	A2LA	Laboratory
American Board for Certification in Orthotics and Prosthetics	ABCOP	Orthotics, Prosthetics
American College of Radiology	ACR	Imaging Centers
American Society for Histocompatibility and Immunogenetics	ASHI	Laboratory
American Speech-Language Hearing Association	ASHA	Hearing Center
Association for the advancement of Blood & Biotherapies	AABB	Blood Collection, Transfusion Services
Board for Orthotist/Prosthetist Certification	BOC	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
Center for Improvement in Healthcare Quality	CIHQ	Hospital, Substance Use Disorder, Free-Standing ER
College of American Pathologists	CAP	Laboratory
Commission for the Accreditation of Birth Centers	CABC	Birth Center
Commission on Accreditation of Ambulance Services	CAAS	Ambulance
Commission on Accreditation of Medical Transport Systems	CAMTS	Air Ambulance
Commission on Accreditation of Rehabilitation Facilities	CARF	Health & Human Service Organizations
Commission on Laboratory Accreditation	COLA	Laboratory
Community Health Accreditation Program	CHAP	Home & Community Based
Council on Accreditation for Children and Family Services, Inc	COA	Health & Human Service Organizations
Det Norske Veritas Healthcare, Inc.	DNV	Hospitals
DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare, etc	DMEPOS	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
Healthcare Organizations (NIAHO)	NIAHO	Hospitals
Healthcare Quality Association on Accreditation	HQAA	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
National Association of Boards of Pharmacy	NABP	Pharmacy
National Children's Alliance Behavioral Health Center of Excellence	BHCOE	Health & Human Service Organizations
National Committee for Quality Assurance	NCQA	Case Mgt, Specialty Pharmacy, Long Term Services & Supports
National Urgent Care Center Accreditation	NUCCA	Urgent Care Centers
Surgical Review Corporation	SRC	Surgery Centers
The Compliance Team	TCT	DME
The Joint Commission (formerly JCAHO)	TJC	Hospitals, Surgery Center, Nursing Homes, Behavioral Health
Urgent Care Center Accreditation	UCCA	Urgent Care Centers

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

Disciplinary action

The Sentara Health Plans Credentialing Committee is responsible for reviewing potential areas warranting corrective action and recommending disciplinary or corrective action for individual practitioners who fail to comply with their Provider Agreement or with Sentara Health Plans policies and procedures.

Grounds for corrective action include, but are not limited to:

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

The Sentara Health Plans Credentialing Committee and other committees may recommend the following actions as applicable:

- Summary suspension
- Termination of participation
- Probationary participation status
- Mandatory attendance at continuing education courses if the quality of care is deficient, but not deficient enough to warrant immediate termination
- Concurrent review by the Sentara Health Plans medical director or designee of the care rendered by the disciplined practitioner
- Other actions as determined by the committee

Summary suspension of the practitioner's clinical privileges may occur without prior investigation or hearing whenever:

- Immediate action is deemed necessary in the interest of patient care or safety, or the orderly operation of Sentara Health Plans
- A practitioner is convicted of a felony

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

Provider Data Accuracy

Sentara Health Plans ensures that data received from providers is accurate and complete by:

- Verifying the accuracy and timeliness of reported data
- Screening the data for completeness, logic, and consistency

- Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts
- Making all collected data available to DMAS and, upon request, to the Centers for Medicare & Medicaid Services (CMS)

Updating Provider Information

Keeping Sentara Health Plans informed of provider updates is an important step to ensuring accurate claims payment, correct provider directories, and member satisfaction. We must have up-to-date information about each provider's practice and data. Please notify Sentara Health Plans in accordance with the timeframes set forth in your Sentara Health Plans Provider Agreement of any changes related to the practice, provider roster, or location/phone number. Sentara Health Plans offers electronic submission for provider update requests. Please use the link below to access, complete, and submit a Provider Update Form. Allow 30 calendar days for the requested provider information to be updated in all Sentara Health Plans systems (60 days for new providers/credentialing requests).

The Provider Update Form is intended for providers who are currently contracted with Sentara Health Plans or are in the contracting process. To access the Provider Update Form, visit this link.

Please note: Tax identification number (TIN), legal business name, product/reimbursement changes, or other changes affecting the Provider Agreement cannot be submitted on the Provider Update Form; these requests should be submitted directly to the appropirate Sentara Health Plans contract manager. Please contact the network contracting team at 1-877-865-9075 for these requests.

Making Sure Providers Appear in the Directory

Sentara Health Plans members rely on Sentara Health Plans and its network providers to maintain complete and accurate information in our provider directories. Keeping Sentara Health Plans informed of provider changes and updates is vital to ensure members have access to the most current provider information at all times.

All Sentara Health Plans providers must give prior notice using the appropriate Update Form for any change of provider information, including but not limited to:

- Provider name, address, and telephone number
- Office hours (as applicable), including whether provider site is open after 5:00 p.m. (Eastern Standard Time) weekdays and on weekends
- Licensing information (e.g., NPI number)
- Specialty/areas of expertise
- Ability to accept new patients
- Group affiliations/hospital affiliations
- Service locations (street address/phone number(s)/indication if on a public transportation route)
- Accommodations for disabilities/ADA accessibility
- Cultural and linguistic capabilities

- Completion of cultural competence training
- Availability of telehealth services
- Website URL, if applicable
- For behavioral health providers, training in and experience treating trauma, areas of specialty, any specific populations, and substance use

In addition, Sentara Health Plans network providers are required to respond to quarterly requests for attestation of provider directory data.

Member Information

Member Visit/Encounter Procedure

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

Copayments, Coinsurance, and Deductibles

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

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

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.

Special Needs Members

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

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

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

Essential Community Providers

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

Primary Care Provider Panels

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

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

Please allow up to 30 business days for the requested provider information to be updated in all Sentara Health Plans systems. The requestor will receive a confirmation email when the request has been completed. After 30 days, if a confirmation email has not been received and/or the updated information is not reflected on the provider's profile in the Sentara Health Plans directory, please email an inquiry for status to **PUStatus@sentara.com**.

PCP Panel Status Options:

- Open and accepting new members
- Not accepting new patients; provider will continue to provide services for established patients, siblings, and spouses switching plans
- Pediatrics provider is not accepting new patients; provider will accept established patients, newborns, and their siblings
- Age restriction
- Covering provider only patients who have seen the provider within the past two years are considered established patients by Sentara Health Plans.

Guidelines for Removing a Member from a PCP Panel

Providers may request that Sentara Health Plans assist a member in the selection of another PCP when the member demonstrates any of the following behaviors:

- Abusive behavior
- Noncompliance with a provider treatment plan
- Failure to establish a provider-patient relationship

Upon notification of these behaviors, member services will make an outreach to the member and assist with selecting a new PCP.

The procedure for removing a member from a provider's panel is as follows:

1. Provider sends a certified letter to Sentara Health Plans notifying the Plan and stating the reason for asking the member to be repaneled to another provider.

2. Provider sends a letter to the member notifying the member that the provider will no longer be serving as the member's PCP and informing the member that Sentara Health Plans will work with them to find a new PCP. Provider must send a copy of the letter to their contract manager in the network management department at Sentara Health Plans by mail or fax.

Providers may not seek or request to have a member terminated from Sentara Health Plans or

transferred to another provider due to the member's medical condition or due to the amount, variety, or cost of covered services required by the member.

Cultural Competency

Sentara Health Plans embraces and promotes cultural humility as a foundational approach to the delivery of services, fostering respectful, inclusive, and culturally competent care to all members including individuals with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and sex, which includes, but is not limited to, sex characteristics, (including intersex traits), pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes.

Culturally competent care allows healthcare providers to appropriately care for and address healthcare concerns, including the beliefs and value systems of enrollers with diverse cultural and linguistic needs.

Providers are encouraged to:

- Build rapport by providing respectful and culturally appropriate care
- Assess the members' need for interpreter or translation services and provide appropriate aids and services to meet the members' needs
- Be mindful of the cultures that may have specific beliefs surrounding health and wellness
- Ensure that the member understands diagnosis, procedures, and follow-up requirements
- Offer health education materials in languages that are common to your patient population and/or per member's preferred language
- Be aware of the tendency to unknowingly stereotype certain cultures
- Ensure staff receive continued education and training in providing culturally competent and linguistically appropriate care

Sentara Health Plans requires network and/or affiliated providers to demonstrate cultural competency in all forms of communication and ensure that cultural differences between providers and members do not impede access and quality healthcare.

Grace Period (Deemed Status)

CMS requires an enrollment grace period for D-SNP members who lose their Medicaid coverage. During this grace period, the member may not be balance billed. Sentara Health Plans' Medicare program allows a three-month grace period for the member to obtain reinstated Medicaid eligibility to maintain D-SNP member enrollment. If at the end of the three-month grace period Medicaid coverage has not been reinstated, the member will also be disenrolled from the D-SNP plan.

Sentara Medicare Member Services

Sentara Health Plans member services are available to Sentara Health Plans members from October 1 through March 31, 7 days a week, from 8 a.m. to 8 p.m. or April 1 through September 30, Monday through Friday, from 8 a.m. to 8 p.m. Numbers are published in member materials to assist members in contacting Sentara Health Plans with questions regarding benefits, eligibility, claims, behavioral health services, or any other question/information related to health plan benefit coverage. The Sentara Community Complete member website is found here.

Care Management

Per CMS and DMAS requirements for full-benefit D-SNP plans, Sentara Health Plans has established a Model of Care (MoC) that is approved by CMS. As a provider for Sentara Health Plans, you will need to complete the annual MoC training. This training is available on the provider portal. Through the MoC, all Sentara Community Complete members receive assistance coordinating their care from a Sentara Medicare care coordinator. Care coordinators conduct comprehensive health risk assessments (HRAs) with 100% of Sentara Community Complete members to stratify them into levels of care, identify areas for intervention and monitoring, and understand the member's existing supports as well as their changing needs for care management.

Sentara Medicare Levels of Care

Where applicable, health risk assessments are repeated periodically to ensure the member receives the appropriate level of care coordination as their condition and circumstances evolve.

However, the care coordinator may adjust the member's level of care at any time on the advice of the interdisciplinary care team (discussed below). This includes transitions of care from inpatient admission to a skilled nursing facility or to the member's home with home health care. Please communicate any changes or updates in the member's status to the care coordinator so Sentara Health Plans can assist with any health care needs and/or transitions.

Individualized Care Plans (ICP)/Health Risk Assessment

Where applicable, the health risk assessment is used as a tool to assist in the development of the member's ICP. Care coordinators develop ICPs with members and providers to reflect the members' health needs, barriers, treatment plans, preferences, and goals. ICPs include:

- Member's goals
- Treatment and education needs
- Type and frequency of services to be provided
- Potential barriers and mitigation plans
- Measurable objectives for meeting goals
- Estimated timetable for achieving the goals and objectives

ICPs are available to providers involved in the member's care on the Sentara Health Plans secure provider portal. Providers may access the ICP, add comments, and send notifications to the care coordinator directly through the portal.

Interdisciplinary Care Team (ICT)

When an ICT is used, the member's interdisciplinary care team includes the member and/or their authorized representative(s). The Care Manager will attempt to include the member's primary care provider, specialists, other providers treating the member, personal care providers if the member is receiving services under EPSDT or Home and Community Based waiver, targeted case manager if the member is receiving targeted care management services, care coordinator (as applicable), and pharmacist (as applicable). As appropriate and at the discretion of the member, the ICT also may include other participants, including, but not limited to, registered nurses, family members, advocates, and state agency or other case managers. The goal of the ICT is to ensure clear communication channels between providers, coordinate care, and

overcome any barriers preventing the member from achieving their health goals.

ICPs and ICTs are an integral part of Sentara Community Complete. Our care coordinators can assist providers with facilitating a member's health care needs. Providers are expected to participate in ICTs for their assigned members, including participation on ICT meetings if possible. Please communicate any changes in the members' health status to the care coordinator so we can assist with any health care needs and/or transitions. Providers may I contact their network educator for further information on care management services for Sentara Community Complete members.

Benefit Information

Sentara Community Complete members receive all benefits covered by original Medicare, Medicaid, plus additional supplemental benefits. General benefit information and the complete evidence of coverage (EOC) for Sentara Community Complete is available on the Sentara Community Complete website at the provider website. Specific Sentara Community Complete benefit information is available to providers by calling provider relations during Sentara Community Complete business hours.

Service Types Typically Covered by Medicare and Medicaid

Medicare Typically Covers	Medicaid Typically Covers
• Inpatient hospital care (medical and psychiatric)	• Medicare copayments
• Outpatient care (medical and psychiatric)	• Hospital and Skilled nursing facility (SNF), when Medicare benefits are exhausted
• Physician and specialist services	• Long-term nursing facility care (custodial)

Medicare Typically Covers	Medicaid Typically Covers
• X-ray, lab, and diagnostic tests • Skilled nursing facility (SNF) care • Home health care	• Home and community-based waiver services like personal care and respite care, environmental modifications, and assistive technology services
• Hospice care (covered by FFS Medicare)	• Community behavioral health and substance use disorder services
• Prescription drugs	• Medicare non-covered services, like over-the-counter (OTC) drugs, some Durable Medical Equipment (DME), and supplies, etc.
• Durable medical equipment	• Medicare non-covered services, like OTC drugs, some DME, and supplies, etc.

Benefit Limitations – Diabetic Test Strips and Continuous Glucose Monitors (CGMs)

Prior Authorization is required for some insulins, insulin pumps, and CGMs. Preferred CGMs are Dexcom and Freestyle Libre.

Diabetic Test Strips are limited to 90/month. Prior Authorization is needed for other

manufacturers or if the order exceeds the 90/month quantity limit. Preferred test strips are LifeScan (OneTouch) and Abbott (Freestyle, Precision).

Supplemental Benefits/Vendors

Hearing
Routine hearing aids and fittings are offered through NationsHearing®.

Chiropractic
Must use the Sentara Health Plans vendor, American Specialty Health (ASH).

Dental (preventive and comprehensive dental)
Must use the Sentara Health Plans vendor, DentaQuest.

Eye exams and eyewear
Must use the Sentara Health Plans vendor, Community Eye Care (CEC).

Over the Counter
Flex card with open access to all NationsBenefits®-participating retail stores or online via Nations Benefits.com.

Routine Podiatry Care
Annual preventive treatments (i.e., cutting or removal of corns, warts, calluses, and nail care) are included.

Fitness Benefit
Must use the Sentara Health Plans vendor, SilverSneakers®.

Personal Emergency Response System (PERS)
Sentara Medicare offers a PERS to members who qualify. Members can call for help in an emergency at the push of a button. This benefit will be administered through NationsBenefits® and Connect America®.

Transportation
Must use the Sentara Health Plans vendor, Modivcare.

Bathroom Safety Supplies
Must use the Sentara Health Plans vendor, NationsBenefits®.

Grocery Allowance
Flex card with open access to all NationsBenefits®- participating retail stores or online via Nations Benefits.com.

Meals
Must use the Sentara Health Plans vendor, NationsBenefits.

In-Home Support Services - Papa Pals

Sentara Medicare offers 40 hours per month of companionship for members who qualify. Papa Pals can assist with things like grocery shopping, medication pick up, technical guidance, and light house help.

MDLIVE Program

Video and phone appointments for routine medical conditions with board-certified internal medicine, family medicine, or emergency medicine physicians 24 hours a day, 7days a week, 365 days a year are included.

Worldwide Emergency/Urgent Care

A $100,000 max plan benefit coverage for emergency or urgent care treatment worldwide is included.

Members should call the member services number on their member ID card for details regarding benefits. Providers should verify eligibility and coverage by contacting the vendor. Please use the member's ID number to obtain eligibility and coverage information. Benefit description details and qualifying criteria can be found here.

Quality Improvement

Through its commitment to excellence, Sentara Health Plans has developed an ongoing comprehensive program directed toward improving the quality of care and services, safety, access, transition of care, health disparities, timeliness, and appropriate utilization of services for our members. The Quality Improvement (QI) program is designed to implement, monitor, evaluate, and improve processes within the scope of our health plan to continuously improve the health of our members every day.

Sentara Health Plans' network and/or affiliated providers must comply with the health plan QI program and actively participate in QI initiatives to improve the delivery of quality of care and services, access and availability to care, and member experience and satisfaction.

HEDIS®[1]

Healthcare Effectiveness Data and Information Set (HEDIS) is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare healthcare quality.

HEDIS performance measures are a part of the NCQA accreditation process. Some of the major areas of performance measured by HEDIS are:

- Effectiveness of care
- Access/Availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health plan descriptive information
- Measures reported using electronic clinical data systems

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Clinical Practice Guidelines

Sentara utilizes the CMS Medicare Coverage database for any coverage rules and/or guidance for Medicare Coverage requirements and criteria for coverage. Sentara Health Plans' Clinical Practice Guidelines do not contradict the existing CMS National Coverage Determinations (NCD), CMS Local Coverage Determinations (LCD), Medicare Benefit Policy Manual, or any other CMS coverage or benefit guidelines. The CMS Medicare Coverage Database is located at this link – MCD Search.

Clinical Practice Guidelines (CPGs) are adopted to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. Sentara Health Plans adopts and disseminates CPGs relevant to its membership for the provision of preventative, acute, and chronic medical and behavioral health services. All clinical or preventive health practice guidelines that are adopted or developed:

- Are based on valid and reliable clinical evidence-based practices or a consensus of healthcare professionals in the respective field

- Consider the needs of the members
- Are reviewed and updated, at a minimum, every two years, or more often, as appropriate
- Are adopted in consultation with contracted health care professionals
- Are disseminated to practitioners and members upon adoption, revision, and request
- Are used to provide a basis for utilization decisions, member education, and service coverage
- Do not contradict existing CMS National Coverage Determinations (NCD), CMS Local Coverage Determinations (LCD), Medicare Benefit Policy Manual, or any other CMS coverage or benefit guidelines. The CMS Medicare Coverage Database is located at this link - MCD Search

Sentara Health Plans requires that network providers utilize appropriate evidence-based clinical practice guidelines through web technology, use of electronic databases, and manual medical record reviews, as applicable, to evaluate appropriateness of care and documentation. A modified approach to the utilization of clinical practice guidelines and nationally recognized protocols may need to be taken to meet the unique needs of all beneficiaries.

These medical and behavioral health guidelines are based on published national guidelines, literature review, and the expert consensus of clinical practitioners. They reflect current recommendations for screening, diagnostic testing, and treatment. These guidelines are published by Sentara Health Plans as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these guidelines, and treatment decisions are always to be made by the practitioner based on their best medical judgement, considering each patient's clinical situation. The Sentara Health Plans guidelines are not intended as a substitute for clinical judgment. Copies of clinical guidelines are available via mail, email, or fax. To request a printed copy of Sentara Health Plans' CPGs, please contact the Quality Improvement and Member Safety Team at 757-252-8400, Option 1, or toll-free at 1-844-620-1015. CPGs are also available online via the Sentara Health Plans website.

Sentara Health Plans Quality Improvement (QI) Program

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

With the application of Continuous Quality Improvement (CQI) principles, Sentara Health Plans aims to provide high-quality, cost-effective care that enables members to remain healthy, manage chronic illnesses and/or disabilities, and maintain or improve members' quality of life. Improvement in health status can be demonstrated by measurable health outcomes. Sentara Health Plans is committed to improving the communities where our members live through participation in public health initiatives on the national, state, and local levels and the achievement of public health goals.

This continuous assessment uses quality improvement methodologies such as Six Sigma, Define-Measure-Analyze-Improve-Control (DMAIC), Root Cause Analysis (RCA), and Plan, Do, Study, Act (PDSA). The QI program is a population-based plan that acts as a road map in addressing common physical and behavioral health conditions identified within our population.

The QI program activities include:

- Identifying performance goals
- Establishing internal and external benchmarks
- Collecting data and establishing baseline measurements
- Analyzing outcomes for barrier identification for performance improvement
- Developing and implementing written remedial/corrective action, as needed

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

The QI program reflects the population served in terms of factors including, but not limited to, age groups, disease categories, special risk statuses, and diversity. The QI program includes monitoring of community-focused programs, practitioner availability and accessibility, coordination and continuity of care, and other programs or standards impacting health outcomes and quality of life.

The QI program provides the structure, framework, and governance used to guide the formal and informal processes for evaluating and improving quality, focusing on the following aspects:

- Appropriateness of health care services
- Effectiveness of care and care outcomes for the populations served
- Responsibility for cost and utilization management
- Member experience of care
- Provider experience of service and support

The QI program uses the Institute for Healthcare Improvement (IHI) Quintuple Aim, DMAS Quality Strategy, CMS guidelines, state and federal mandates, Bureau of Insurance (BOI), and NCQA Standards as guiding principles to shape the QI Program efforts and provide the highest quality of care to better serve Sentara Health Plans' members and the community. The scope of the QI Program includes oversight of all aspects of clinical and administrative services provided to Sentara Health Plans members, including:

- Program design and structure
- Quality improvement activities that comply with CMS, NCQA, DMAS, and other regulatory entities, including contractual and regulatory reporting requirements
- Care Management (to include Complex Case Management, Behavioral Health, Care Transitions, and End of Life Planning) and Chronic Care Management programs that are member-centric and address the healthcare needs of members with complex medical, physical, and mental health conditions, assessments of drug utilization for appropriateness and cost-effectiveness
- Utilization Management focuses on providing the appropriate level of service to members
- Grievances and appeals
- High-quality customer service standards and processes
- Benchmarks for preventive, chronic, and quality of care measures
- Credentialing and re-credentialing of physicians, practitioners, and facilities

- Compliance with NCQA accreditation standards
- Audits and evaluations of clinical services and processes
- Development and implementation of clinical standards and guidelines
- Measuring effectiveness
- Evidence-based care delivery
- Potential quality of care and safety concerns

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

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

The primary objective of Sentara Health Plans' QI program is to continuously improve the quality of care provided to enhance the members' overall health status. Improvement in health status is measured through Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure data, internal quality studies, and health outcomes data with defined areas of focus. Sentara Health Plans have defined objectives to support each goal in the pursuit of improved outcomes.

The following are identified functions of the QI program:

- Provide an annual Quality Program Description, Quality Annual Evaluation, and Quality Work Plan
- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care and service, including quality, utilization, member service, credentialing, and other related functions managed at the plan level or delegated to vendor organizations
- Identify and develop opportunities and interventions to improve care and services
- Identify and address instances of substandard quality of care concerns
- Monitor, track, and trend the implementation and outcomes of quality interventions
- Evaluate the effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards
- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into primary care practices
- Report on relationships between QI department staff and the QI Committee and subcommittee structure
- Provide resources and analytical support
- Collaborate interdepartmentally for QI-related activities
- Outline efforts to monitor and improve behavioral healthcare and the role of designated behavioral healthcare practitioners in the QI program
- Define the role of the designated physician within the QI program, which includes participating in or advising the Quality Improvement Committee (QIC) or a subcommittee that reports to the QIC

- Define the role, function, and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities (e.g., clinical subcommittees, ad hoc task forces, or multidisciplinary work groups or subcommittees)
- Describe practitioner participation in the QI committee and how participating practitioners are representative of the specialties in the organization's network (including those involved in QI subcommittees)
- Outline Sentara Health Plans' approach to addressing the cultural and linguistic needs of its membership
- Provide guidance on how to report a member's critical incidents (including quality of care, quality of service, and sentinel events)
- Provide training materials for providers and organization employees on cultural competency, bias, and/or diversity and inclusion
- Coordinate performance measure monitoring for improvement and sustainability
- Utilize performance measure data for continuous quality improvement (CQI) activities

Goals of the Quality Improvement Program

One of the primary goals of the Sentara Health Plans' QI Program is to achieve a 5-star rating from NCQA and CMS, respectively, by ensuring the delivery of high-quality, culturally competent healthcare, particularly to members with identified healthcare disparities. Our care service delivery modalities emphasize primary medical and specialty healthcare services, behavioral health, long-term services and supports, care coordination, and pharmaceutical services. The QI program concentrates on evaluating both the quality of care offered and the appropriateness of care provided. This approach allows Sentara Health Plans to:

- Reduce healthcare disparities in clinical areas
- Improve cultural competency in materials and communications
- Improve network adequacy to meet the needs of underserved groups
- Improve other areas of needs that the organization deems appropriate
- Include a dynamic Work Plan that reflects ongoing progress on QI activities throughout the year
- Plan QI activities and objectives for improving the quality and safety of clinical care, quality of service, and member experience
- Monitor previously identified issues
- Evaluate the effectiveness of the QI Program's Annual Evaluation by analyzing performance measure outcomes
- Continuously meet regulatory and accreditation requirements
- Create a system of improved health outcomes for the populations served
- Improve the overall quality of life of members through the continuous enhancement of comprehensive health management programs, including Performance Improvement Projects (PIPs) and other Quality Improvement projects
- Make care safer by reducing variation in practice and enhancing communication across the continuum
- Strengthening member and caregiver engagement in achieving improved health outcomes
- Ensure culturally competent care delivery through practitioner cultural education, including the provision of information, training, and tools to support culturally competent communication

For hard copies or information about the QI Program at Sentara Health Plans, please contact the

Quality Improvement and Member Safety Team at 757-252-8400, option 1, or toll-free at 1-844-620-1015, option 1.

NCQA's website, ncqa.org, contains information to help consumers, employers, and others make more informed health decisions.

Critical Incident Reporting

A critical incident is defined as any actual, or alleged, event or situation that threatens or impacts the physical, psychological, or emotional health, safety, or well-being of the member. Critical incidents are categorized as either quality of care incidents, sentinel events, or other critical incidents as defined below:

- Quality-of-care incident is any incident that calls into question the competence or professional conduct of a healthcare provider while providing medical services and has adversely affected, or could adversely affect, the health or welfare of a member. These are incidents of a less critical nature than those defined as sentinel events.
- Sentinel event is a patient safety event involving a sentinel death (not primarily related to the natural course of the illness or underlying condition for which the member was being treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function that leads to permanent or severe temporary harm. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. **All sentinel events are critical incidents**.
- Another critical incident is an event or situation that creates a significant risk to the physical or mental health, safety, or well-being of a member, not resulting from a quality-of-care incident and less severe than a sentinel event.

Providers must report critical incidents that occur during:

- The provision of services to members in nursing facilities, inpatient behavioral health or HCBS settings, hospital, PCP, specialist, transportation, or other healthcare settings
- Participation in or receipt of mental health services, ARTS, or waiver services in any setting (e.g., adult day care center, a member's home, or any other community-based setting)

Examples of Reportable Critical Incidents:

- Abuse
- Attempted suicide
- Deviation from standards of care
- Exploitation, financial or otherwise
- Medical error
- Medication discrepancy
- Missing person
- Neglect
- Sentinel death
- Serious injury (including falls that require medical evaluation)
- Theft
- Other

Provider-preventable Conditions and Services (Never Events)

A provider-preventable condition (PPC) means a condition that meets the definition of a "healthcare-acquired condition" (HAC) or an "other provider-preventable condition" including, but not limited to:

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

Serious Reportable Events (SREs)

Serious reportable events (SREs) are events that are clearly identifiable and measurable, usually preventable, and are serious in their consequences, such as resulting in death or loss of a body part, injury more than transient loss of a body function, or assault. These are severely significant adverse events that should never occur.

Examples of SREs include, but are not limited to the following:

- Death (patient suicide, attempted suicide, homicide, and/or self-harm while in a healthcare setting)
- Falls (resulting in death or serious injury while being cared for in a healthcare setting)
- Pressure ulcers that are unstageable or stage III or IV acquired post-admission/presentation to a healthcare setting
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- Restraint use (physical restraints or bedrails) that results in death, requires hospitalization, or results in loss of function
- Patient death or serious injury associated with patient elopement (disappearance) while being cared for in a healthcare setting
- Abuse/assault on a patient or staff member on healthcare facility grounds

Abuse, Neglect, or Exploitation

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

- Person licensed, certified, or registered by health regulatory boards listed in Code of Virginia § 54.1-2503, except for persons licensed by the Board of Veterinary Medicine
- Mental health services provider as defined in § 54.1 -2400.1
- Emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5, unless such provider immediately reports the suspected abuse, neglect, or exploitation directly to the attending physician at the hospital to which the adult is transported, who will make such report forthwith
- Guardian or conservator of an adult
- Person employed by, or contracted with, a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity

Procedures/Guidelines

Sentara Health Plans requires all network and affiliated providers to report critical incidents within

24 hours of discovery via the approved Critical Incident Reporting Form located on the Sentara Health Plans website. An initial report of an incident may be submitted verbally within 24 hours but must be followed up with a written report within 48 hours.

If the critical incident includes notifying Adult Protective Services (APS) or Child Protective Services (CPS), the following numbers may be used:

APS: 1-888-832-3858
CPS: 1-800-552-7096

Notify Sentara Health Plans of a critical incident either by phone, fax, or email within 24 hours of the incident. Sentara Health Plans' contact information to report a critical incident is located on the DMAS Critical Incident Reporting Form or the Sentara Health Plans Key Contact Information at the top of this document.

Provider Office Quality of Care/Service Site Visit

A Provider Office Site Visit will be conducted by the Quality Department secondary to a Quality of Care (QOC)/Quality of Service (QOS) event and/or member grievance, or complaint, related to a QOC/QOS event. An office site visit may be conducted as a result of one or more quality concerns including, but not limited to, the following:

- Critical incidents (QOC/QOS/Sentinel Event)
- Member complaints/grievances related to:
  - Quality of care/quality of service
  - Provider office physical accessibility
  - Provider office physical appearance
  - Provider office adequacy of waiting and examining room space
  - Provider office adequacy OP of medical/treatment record-keeping
  - Provider office equipment accessibility
- Reported member safety concerns from Sentara Health Plans' employees

A provider office visit will be conducted as expeditiously as the quality event, or complaint, necessitates, but no later than 30 days of the identified quality concern. All network providers must comply with Sentara Health Plans Quality Department's quality initiatives to investigate such concerns and must meet a predetermined minimum performance compliance threshold set forth by Sentara Health Plans. If issues are found during the site visit, a Corrective and Preventive Action (CAPA) Plan may be initiated by Sentara Health Plans in its sole discretion. If the quality concern(s) remains unresolved after the specified timeframe, a referral will be made to the appropriate department and/or committee for review.

Failure To Comply with Review Programs

Failure to comply with utilization management and quality improvement programs could be grounds for corrective action in addition to requirements for repayment of identified overpayments and/or being removed from the network. The failure of the provider to follow the policies and procedures of Sentara Health Plans' credential verification, quality assurance, risk, or utilization management programs regulations can lead to exclusion from federal funding, including payments from Medicare and Medicaid, as well as criminal and civil liability.

Health And Preventive Services

Member Services

Preventive health services for members include specific interventions to increase preventive health practices and to decrease identified health risks.

The patient identification manager (PIM) reminder system is a computer-based direct mail program designed to reach members and providers monthly to promote health. These initiatives support HEDIS improvement requirements. Mailings and communications may include:

- **Birthday Cards –** Plan members receive a birthday card during their birth month from Sentara Health Plans.
- **Healthy Pregnancy Mailings -** Once the health plan learns of a member's pregnancy, the member receives communication (or materials) from the health plan. Our messages include pregnancy resources and tips for mothers-to-be.

Health and preventive services by Sentara Health Plans offer health improvement programs, which include health risk identification and risk reduction strategies. Members may complete an online personal health assessment (PHA), which generates an immediate and detailed report with specific risk-reduction strategy recommendations. A shorter report that the member can take to their healthcare provider is also available. Members with diabetes, asthma, or cardiovascular disease, and those who are pregnant, are referred to Clinical Care Services.

Health Risk Reduction Programs

Several health risk reduction programs are available free of charge to health plan members regularly throughout the year. A current list of programs is available to members on the member website and includes:

Digital Lunch-and-Learn Webinars/Podcasts

As part of our ongoing effort to address relevant and timely risk-reduction education, our team of health educators host free, monthly webinars on a range of well-being topics. Available **here**, this series is open to all members. Past webinars are archived for viewing anytime. Topics include Tobacco Use and Cholesterol and Blood Pressure; Probiotics and Gut Health; Planting Your Money Tree; The Importance of Water Intake; Becoming Mindful, Not Mind Full; and Sleep Deprivation and Heart Health.

Individual Self-Paced Programs

Our unique, self-paced, and award-winning individual wellness programs are offered at no cost to all Sentara Health Plans members. Members can visit the **Prevention and Wellness** page to download programs on demand or place an order for materials to be delivered via U.S. mail. The programs use a variety of media to engage the member in learning about the risks and benefits of their behavior and offer tools for the member to take charge and make healthy changes, including:

- Healthy Heart Yoga: Yoga programs include stretching and strengthening exercises to help improve flexibility, strength, and cardiovascular health. Chair yoga is also available.
- Eating for Life: This award-winning educational program helps participants develop healthy eating and exercise habits.

- Guided Meditation – A Journey Toward Health: This program invites listeners to experience a calm, peaceful retreat from everyday stressors.
- Qigong: This program helps your body to relax mentally and physically. The movements of this ancient practice enhance blood flow, release muscle tension, and improve balance.
- Stay Smokeless for Life: This education and support program helps people who want to quit using tobacco.
- MoveAbout: This program focuses on increasing regular activity. It includes information to incorporate movement into daily activities.
- Healthy Habits, Healthy You: This educational program offers helpful ways to prevent Type 2 diabetes and heart disease by making healthy food choices, managing body weight, exercising, and finding ways to relax and get more sleep.

Health Education and Coaching Services

MyLife MyPlan Connection (powered in partnership with WebMD)

Through a partnership with WebMD® Health Services, we offer our members flexible programs, expert guidance, and inspiration to take charge of their health—whether they are continuing healthy behaviors or making a change to improve their health. Sentarahealthplans.com and the Sentara Health Plans mobile app provide a direct connection to each member's personalized WebMD Health Services online portal, streamlining how members can access the tools and education they need to sustain healthy behaviors. It all begins when the member completes a personal health assessment, which creates the foundation for their health record and coaching program. The online portal also offers a comprehensive activities tool known as Daily Habits. The Daily Habits tool delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy behaviors in a fun way.

Personal Health Assessments (PHA)

The PHA is an advanced health profiling/risk assessment tool that scores an individual's health status, calculates risk levels, and provides recommendations for health improvement and behavior change. It takes approximately 12 minutes and is conveniently available for desktops, laptops, tablets, and mobile phones. Features include simple language for easy reading, gaming technology to drive engagement, and helpful "coach-like" notes.

The assessment analyzes different health risk factors that affect an individual's health and well-being. These factors fall into personal health status and lifestyle choices and habits. Based on an individual's responses, they receive a personalized score on 11 modifiable risk factors and the likelihood they will develop certain medical conditions.

A results summary screen with the participant's score, personalized steps to improve health, and risk and condition reports is the first thing the member sees upon completing their health assessment. Program recommendations include other wellness services such as telephonic or digital health coaching or referral to one of our disease management programs. The objective is to guide individuals to the appropriate programs and resources and serve as the foundation for an overarching health and benefits management strategy. All reports are available for printing, including a physician-specific report that the member can take to their annual physician visit.

Member Dashboard with Personalized Risk Education

Members' wellness portal dashboards feature a dynamic display highlighting articles, resources, and personalized recommendations based on the information provided by the member. For example, if a member has identified a goal or issue related to stress, they will see content related to stress management. As another example, if the member indicated a high BMI on their health assessment, they would see content related to losing weight.

Fitness Device Integration

Our wellness portal offers the ability to integrate a variety of biometric device brands, including (but not limited to) Adidas, Fitbit, Garmin, iHealth, Jawbone, Life Fitness, Medisana, Microsoft, Misfit, Moveable, Nokia, Polar, Suunto, Sync, Telcare, TomTom, Under Armour, Withings, and YOO. The portal also offers integration with many fitness apps such as Adidas, Daily Mile, Garmin, iHealth, Jawbone, MapMyFitness, Moves, Nokia Healthmate, RunKeeper, Strava, Suunto, and Withings. When a device is linked to the WebMD portal, the information collected on the device flows seamlessly into various programs in the well-being platform.

Diabetes Prevention Program

In partnership with Omada Health, Sentara Health Plans offers members who qualify a digital, lifestyle-change program focused on reducing the risk of obesity-related chronic disease. This program combines the latest technology with ongoing support so participants can make changes to improve their health. The program includes a wireless smart scale, weekly online lessons, professional health coaching, and small online peer groups that offer real-time support. Members can determine if they qualify for the program by visiting **Omada** and completing the online screening tool.

Resources

We offer members several resource libraries that host up-to-date information to help answer their health and medication questions. With thousands of articles and helpful tools, such as health education videos, recipes, and quizzes, members can easily find trusted answers through our wellness portal.

Communications

Health and Preventive Services contributes news and current preventive health initiatives to the Sentara Health Plans provider newsletter and other Sentara Health Plans publications.

Healthcare Services

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

Types of issues that may be referred to healthcare services:

- Members with complex medical issues who utilize multiple services
- Members who are nonadherent with treatment plans
- Members who frequently utilize services without consulting a PCP or specialist
- Members who frequently utilize the ER
- Members who could benefit from chronic condition management of heart failure, metabolic cardiovascular disease, transplant, behavioral health conditions, asthma, COPD, or obesity
- Members who could benefit from condition management during pregnancy, postpartum, and need assistance with navigating infertility

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

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

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

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

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

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

Clinical Care Services

For all members, the following apply:

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

PCPs or specialists **may not** authorize non-covered benefits or out-of-network services unless it is medically necessary and they have received prior authorization from Sentara Health Plans.

Exceptions for prior authorization apply for emergencies and network accessibility.

Behavioral Health Services Access

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

Provider-to-Provider Communication

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

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

Medical Clinical Care Services: Authorization

Prior Authorization via the Sentara Health Plans Provider Portal

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

Prior Authorization Forms

All prior authorization forms are available on the provider website **here**. The fax number varies based on the service requested and the member's Sentara Health Plans product type. To ensure a provider's request is not delayed, providers should use the fax number listed on the authorization form for the specific requested service for D-SNP programs.

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

Clinical Care Service Availability

Clinical care service personnel are available Monday through Friday, 8 a.m. to 5 p.m. Eastern Time. Confidential voicemail is available Monday through Friday, 5 p.m. to 8 a.m., and 24 hours on weekends and holidays. D-SNP representatives can be reached at 1-888-946-1167.

Prior-Authorization Procedures and Requirements

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

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

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

Failure to pre-authorize services may result in the denial of payment, and the provider may be held responsible for the cost of services rendered.

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

The Centers for Medicare and Medicaid Services (CMS) defines an expedited request as a request for a determination that must be made quickly because waiting for a standard decision could seriously jeopardize a member's health, life, or ability to regain maximum function.

Prior authorization determines the existence of medical necessity. It does not determine the level of payment or coverage and therefore does not guarantee payment. Payment decisions are also subject to eligibility for services on the procedure date, benefits provided through the member's health plan, and a provider's adherence to its provider agreement and policies of Sentara Health Plans, CMS, and DMAS. Sentara Health Plans will coordinate the processing of prior authorization requests between Medicare and Medicaid.

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

- All inpatient hospitalizations
- All partial hospitalizations (mental health or substance abuse)
- All skilled nursing facility admissions
- All acute rehabilitation
- All Intensive outpatient programs
- All out-of-area services or referrals to nonparticipating providers (prior to scheduling)

For all outpatient prior authorization requirements by procedure, please refer to the Sentara Health Plans Prior Auth List (PAL) found here.

For all inpatient admissions (emergent and scheduled admissions) will require authorization and should be completed online via the Sentara Health Plans provider portal.

The provider or office staff should provide the following information when obtaining prior authorization for admission:

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

Secondary Payer - Prior Authorizations

Sentara Health Plans does not require prior authorization when acting as the secondary payer except in the following situations:

- The primary insurance does not cover the service;
- The member has exhausted their benefits under the primary payer.

In either of these circumstances, Sentara Health Plans becomes the primary payer and prior authorization is required, if it is required for the specific service type.

Sentara Health Plans Oncology Program

The Sentara Health Plans oncology program promotes evidence-based, high-value care for members receiving chemotherapy drug regimens and/or radiation therapy for the treatment of cancer. The program also includes genetic and molecular testing for the diagnosis and management of cancers.

Providers are required to pre-authorize cancer radiation therapy, medical oncology and genetic/molecular testing services.

The oncology program applies to D-SNP members.

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

1. 24/7 access to cancer nurses via video, chat, and phone
2. Cancer-specific mental health therapists available by appointment
3. Personalized nutrition support from registered dietitians specializing in cancer care
4. An extensive library of clinically approved articles, videos, and virtual events

Genetic Testing

Providers must obtain prior authorization from Sentara Health Plans **prior** to the member receiving services for all genetic testing except Non-Invasive Prenatal Testing (NIPT). Testing must be performed at participating specialty laboratories.

Behavioral Health Prior-Authorization Requirement

Routine Outpatient Services

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

Clinical Care Policies/Criteria

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

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

- Review of Medical Care Guidelines (MCG)
- Literature review of specialty journals, medical/professional journals, PubMed, research studies/outcomes, and articles
- Government regulations and requirements, including Local Coverage Determination (LCD) and National Coverage Determination (NCD)
- Assistance of appropriate network providers/specialists
- Specialty advisors

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

Pre-Service Review

Medical or behavioral health elective services requiring prior authorization should be submitted as soon as possible or at least 14 calendar days prior to scheduling procedures. This allows the clinical reviewers and medical directors to review all submitted documentation and request other information or test results to make authorization determinations. These elective decisions will be

rendered within 14 calendar days from receipt of all requested information. Urgent cases will be completed within 72 hours.

Admission Review

Clinical care services utilization review nurses conduct admission reviews within 3 calendar days of the patient's admission once the authorization request is received. If, at the time of review, there is no record of a preadmission prior-authorization request, Sentara Health Plans will determine if the admission was medically necessary. If the admission was medically necessary and the claim satisfies all other criteria for full reimbursement, Sentara Health Plans will pay the claim.

Concurrent Review

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

Post-Service/Retrospective Review

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

Gynecological Care

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

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

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

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

Abortions are not covered as Medicare procedures except:

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

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

24/7 Nurse Advice Line Program

The 24/7 Nurse Advice Line provides an avenue of care for members who need advice after their provider's office is closed. Registered nurses are available to provide direction and education for patients whose needs range from a sore throat to surgery questions. These nurses follow a set of protocols written and approved by physicians in providing educational information.

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

- the member ID number of the person who is ill or has been injured - this number is on the front of the member ID card
- detailed information regarding illness or injury
- any other relevant medical information about the patient, such as other medical conditions or prescriptions

Benefits

Providers benefit from the program in several ways:

- The member receives advice to meet appropriate healthcare needs.
- The program reduces the number of after-hours non-emergency calls providers receive.
- The nurse will contact a provider if the situation requires it.

Information

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

Additional Ancillary Services

Depending on the D-SNP plan, covered ancillary/other services, such as home health, DME, and prosthetic appliances, require prior authorization. Details are outlined in the information provided below.

Medical Transportation Services/Ambulance

Emergency Transport

- In an emergency, Sentara Health Plans will cover ambulance services from the home or the place of injury or medical emergency to the nearest hospital where appropriate treatment can be provided.
- Ambulance providers must obtain prior authorization for applicable services whenever possible. In cases requiring services after routine business hours or other circumstances where services were provided in good faith, Sentara Health Plans will not withhold authorization if the patient is a current Sentara Health Plans member, medical necessity warrants the services, and the authorization request is made within 30 days of the service.

Dialysis Services

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

Oxygen Policy

Members may receive oxygen through a DME/respiratory therapy provider. Oxygen therapy receives prior authorization by clinical care services based upon diagnosis and medical necessity. Oxygen services require a physician order and oxygen saturation level meeting medical criteria. All supplies are included in the rental reimbursement.

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

All requests for liquid oxygen will require the ordering physician to submit the medical necessity ordering form/oxygen and must be approved by Sentara Health Plans' medical director. Initial authorizations will be set up for either three months or one year, depending on the episode of illness. Oxygen systems do not fall under the rental-to-purchase procedure.

Prosthetics and Orthotics

Prosthetics and orthotics are covered as outlined by CMS and DMAS, and when determined to be necessary and appropriately pre-authorized by Sentara Health Plans' clinical care services. Please contact provider services to determine the member's coverage.

Skilled Nursing Facilities (SNFs)

Placement in a skilled nursing facility requires prior authorization.

Sleep Studies

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

Pharmacy Services

The Sentara Community Complete formulary is available on the provider website.

Mail-order pharmacy services are available for a minimum of a 63-day supply and a maximum of a 90-day supply. Order forms are available from the Sentara Community Complete website above. Prescriptions are generally received within 14 days.

Laboratory Services

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

In-Office Lab

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

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

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

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

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

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

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

In-Office Laboratory Services Reimbursement

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

Reference Lab Providers

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

Laboratory Services Reporting

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

Laboratory Draw Sites

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

Preoperative Lab and X-ray

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

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

Toxicology Lab Services and Medication Compliance Testing

Toxicology lab services are available for all Sentara Health Plans service areas. In-depth medication compliance services, including pain management and substance use testing, are available for Sentara Health Plans' medical and behavioral health providers for all Sentara Health Plans products.

Billing and Payments

Contracted Amounts/Crossover Claims

When Sentara Health Plans receives a claim under a D-SNP plan, it first bills Medicare and then Medicaid. First, Sentara Health Plans processes the claim and adjudicates it under Medicare rules. Sentara Health Plans deducts the contractually allowable charge, deductible, and/or coinsurance and pays the remaining amount. Then, Sentara Health Plans crosses the claim over to the Medicaid side, where it determines how much of the remaining allowable charges Medicaid is obligated to pay the provider on behalf of the member for their deductible and/or coinsurance. Sentara Health Plans also calculates how much of the deductible and/or coinsurance the provider is contractually obligated to write off. Generally, on the Medicare side, the member's annual deductible must be incurred before any Medicare payment is made. Usually once a deductible is met for a particular type of service, no more deductible applies for that type of service for the remainder of the year. Claims billed to Medicaid for the member's deductible and/or coinsurance are known as crossover claims.

Hold Harmless Policy

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

Appropriate Service and Coverage

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

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

Medical Necessity

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

Sentara Health Plans may deny claims for services deemed medically unnecessary.

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

- The member has been informed prior to receiving the services that those services may not be covered under the member's benefit plan.
- The member has agreed in writing to pay for the services at the time or before services are rendered.

- A patient should be billed directly if it cannot be proven that the patient is a member at the time of service. If, within twelve months of the date of service, it is determined that the patient is indeed a member, you must refund the member any payments made **more than** applicable copayments, coinsurance, or deductibles and file a claim for the service rendered.

Payment Policies

Sentara Health Plans' payment policies are accessible through the Availity provider portal under the resources tab in Payer Spaces. The policies explain acceptable billing and coding practices to equip providers with information for accurate claims submission. Sentara Health Plans will inform providers as new policies are published. To access the policies, providers must have an active Availity Essentials provider portal account.

Corrected Claim Submission of a Previously Billed Claim

UB-04 Claims

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

CMS-1500 Claims

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

Inpatient Billing Information

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

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

An inpatient stay must be billed with different "from" and "through" dates. The date of discharge does not count as a full-confinement day since the member is normally discharged before noon,

and therefore, there is no reimbursement.

Pre-Admission Testing

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

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

Readmissions

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

Never Events and Provider-Preventable Condition Claims

Sentara Health Plans requires providers to code claims consistent with CMS “Present on Admission” guidelines and follow CMS “Never Events” guidelines.

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

No reduction in payment for a “never event” will be imposed when the condition defined as a “never event” for a member existed prior to the initiation of treatment for that member. Reductions in reimbursement may be limited to the extent that the following apply:

- The identified provider preventable conditions (i.e., “Never Events”) would otherwise result in an increase in payment; and
- Sentara Health Plans can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions

Non-payment of provider preventable conditions must not prevent access to services for members.

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

Providers are required to report "never events" associated with claims for payment or member treatments for which payment would otherwise be made.

Furloughs

Furloughs (revenue code 018X) occur when a member is admitted for an inpatient stay, discharged for no more than ten days, and then readmitted under the same authorization. Examples include situations in which surgery could not be scheduled immediately, a specific surgical team was not available, or further treatment is indicated following diagnostic tests, but cannot begin immediately.

Interim Billing

Interim billing indicates that a series of claims may be received for the same confinement or course of inpatient treatment that spans more than thirty (30) consecutive days. Interim billing may be based on the month's end date. The appropriate bill type should be indicated for each claim.

Organ Transplants

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

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

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

Inpatient Denials/Adverse Decisions

If the attending physician continues to hospitalize a member who does not meet the medical necessity criteria, or there are hospital-related delays (such as scheduling), all claims for the hospital from that day forward will be denied for payment. The member cannot be billed.

If the member remains hospitalized because a test ordered by the attending physician is not performed due to hospital-related problems (such as scheduling and pretesting errors), then all claims from that day forward for the hospital will be denied. The member cannot be billed.

If a family member insists on continued hospitalization (even though both the attending physician and Sentara Health Plans agree that the hospitalization is no longer medically necessary), the claims related to the additional days will be denied.

For all medically unnecessary dates of service, both the provider and member will receive a letter of denial of payment from Sentara Health Plans. The letter will specify which dates of service are to be denied, which claims are affected (hospital and/or attending physician), and the party responsible for the charges.

Facility Outpatient Services

Members may receive certain outpatient services (i.e., diagnostic tests, chemotherapy, radiation

therapy, dialysis, physical therapy, nutritional counseling, etc.) per their benefit plan. Providers must use UB bill type 131 for outpatient services.

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

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

Coordination of Benefits (COB)

For D-SNP members, Sentara Health Plans will coordinate the claim processing for primary and secondary; therefore, no secondary claim submission is required for payment. This applies to all D-SNP members, regardless of whether the member has Sentara Health Plans for Medicare or traditional Medicare (i.e., not a Medicare Advantage plan).

Overpayments and Recoveries

If a provider receives an overpayment, the provider should complete and return the Provider Refund Form to Sentara Health Plans within 60 calendar days after the date on which the overpayment was identified. The form should be completed in its entirety stating the identified problem and the provider should include a refund check. As an alternative, providers that would like to have the overpayment retracted should complete and return the Provider Reconsideration form found here.

As part of the Sentara Health Plans audit process, Sentara Health Plans and/or its subcontractors may use statistical sampling and extrapolation of claims in determining the amount of an overpayment made to a provider. The extrapolation methodology utilized by Sentara Health Plans is consistent with the methodology authorized in the Medicare Program Integrity Manual.

In most cases, when a provider is paid in error, Sentara Health Plans automatically executes a retraction with 30 days' advance notice to the provider stating the reason for the retraction. In accordance with 42 CFR 401.305, the lookback period for Medicare is 6 years from the date the overpayment was received.

If retraction is not possible and the provider would prefer to send a refund, please send a copy of the remit, the reason the claim was paid in error, and the payment check within 30 days to the Sentara Health Plans provider receivables address in the **"Sentara Health Plans Key Contact Information"** section of this manual.

If the remit is not available, please send a check with the member's name, member ID number, the reason the claim was paid in error, and the date of service to the provider's receivables address. Please be sure to make the check payable to the company that sent you the check.

Reimbursement

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

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

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

Provider Fee Schedule

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

Claims

Providers submit claims directly to Sentara Community Complete. Sentara Health Plans will coordinate the claim processing for primary and secondary, and no claim submission for secondary claims is required. If the member has traditional Medicare, CMS will submit the crossover claim directly to Sentara Health Plans (Medicaid) for processing, and no secondary claim is required.

Sentara Community Complete (Medicare) is the primary on all Medicare-covered services. Sentara Health Plans' Medicaid program is typically secondary but is primary on non-Medicare covered services.

Providers cannot bill D-SNP members for services not reimbursed by Medicaid or Sentara Community Complete during the enrollment grace period or for the difference between what has been paid and the billed charges.
Skilled nursing facility claims must be submitted with the appropriate resource utilization group (RUG) code and assessment identifier.

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

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

NPI

All claims submitted to Sentara Health Plans must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number and taxonomy code are not Clean Claims and will be rejected or denied.

Completing the CMS-1500 Claim Form

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

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

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

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

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

Paper Claims

All paper claims should be sent to the claim address on the member's ID card. Handwritten claims are not accepted by Sentara Health Plans.

Common Reasons for Claim Rejection

- There are errors in the member's name.
- Hyphenated last names are submitted incorrectly.
- The birth date submitted doesn't match the birth date associated with the member ID number.

Remittance Advice

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

Negative Provider Status

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

Interim Reports

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

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

Pending Claims

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

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

Timely Filing Policy

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

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

Duplicate Claims and Corrections

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

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

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

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

Claim Reconsiderations

A *reconsideration*—distinct from a *claim correction*—is a written request submitted by the provider seeking a review of how a claim was adjudicated It is important to note that a reconsideration does not involve any changes to the original claim. The reconsideration filing deadline is 365 days from the last date of service.

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

The Provider Reconsideration Form is available on the health plan website found here or by calling provider services.

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

Providers will receive written letters indicating that the original claim decision will be upheld when reconsiderations are submitted without complete information. If the provider is not satisfied with the initial reconsideration outcome, a second reconsideration may be requested based on the upheld reason within 60 days from the date on the determination letter.

Late Claim Reconsiderations

Requests for waivers to the timely filing requirements due to an exceptional circumstance must be made in writing and should be submitted to the Sentara Health Plans claims department. The request should explain the reason for the late filing and Sentara Health Plans may only grant extensions for good cause shown.

Submit Reconsideration requests through the following methods:

Electronic

For Medicare, providers can submit reconsideration requests electronically by using Sentara Health Plans’ Claim Reconsideration Portal. For providers who have not used the Claim Reconsideration Portal in the past, please register by selecting "Need an account?".

Mail

Providers can mail requests to the following addresses:
Medical Claims: PO Box 8203, Kingston, NY 12402-8203
Behavioral Health Claims: PO Box 8204, Kingston, NY 12402-8204

Changes in Insurance Information

If a provider receives corrected insurance information from the member and provides supporting documentation (for example, original dated registration, new registration, etc.), the provider may submit an original or corrected claim to Sentara Health Plans within 120 days of receipt of the new information.

Retroactive Disenrollment

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

Claims Denied in Error

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

Workers' Compensation

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

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

Electronic Claims and Electronic Funds Transfer

Electronic Funds Transfer (EFT)

EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 48 hours after payments are processed. 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. For Medicare claims, EFT and ERA will be issued through Zelis Payments Network. This will require a Zelis account.

Current Zelis Users

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

New Zelis Users – How to Register:

If not enrolled in the Zelis Payments Network, an enrollment option must be completed to continue receiving electronic payments, or the payment will be issued by check and sent via U.S. mail. Alternative payment options are also available, including the Automated Clearing House (ACH) Network, virtual credit card, and paper check. If you have any questions or want to change your payment method, please call 1-855-496-1571 or visit the Zelis website.

Sentara Health Plans ePayment Center

To enroll in the Sentara Health Plans ePayment center, please call 1-855-774-4392, send an email to help@epayment.center, or visit us online.

Filing Claims Electronically

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

- Claims can be submitted through Availity or any clearinghouse that can connect through Availity.
- The Sentara Health Plans payer ID number is **54154**.
- Providers who can receive data files in the HIPAA (Health Insurance Portability and Accountability Act) compliant ANSI 835 format may elect to receive EFT/ERA from Zelis or Sentara Health Plans ePayment Center. The 835 transaction contains remittance information as well as the electronic funds transfer.

Inquiries about direct claims submission or EFT/ERA transactions may be submitted by email to **EFT_ERA_Inquiry@sentara.com**.

- All claims must be submitted within the timely filing policy provisions stated in your Provider Agreement. Please see the "**Timely Filing Policy**" section in the "**Claims"** chapter of this manual.
- Claims submitted electronically will be accepted when billed under the member's Sentara Health Plans member ID. Providers should first review their clearinghouse requirements for submission of member identification to confirm that their clearinghouse will accept claims using their chosen option for submission.

- Claims submitted must have charge amounts. Claims for zero charge amounts will be rejected.
- Claims submitted electronically will be processed within 24 hours of receipt.

Required Claims Information

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

Birth Date

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

Corrected Claim Submissions

Sentara Health Plans accepts the following corrections electronically:

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

Coordination of Benefits Claim Submissions

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

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

Status Reports

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

Support for Electronic Claims Filing

Contact your current EDI vendor for:

- Problems with transmission
- Level one or level two errors

Contact provider services for:

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

Information for Specific Claim Types (A-Z)

Allergy Claims

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

Code 99211

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

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

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

Fluoroscopic Guidance and Contrast

Sentara Health Plans allows the reimbursement of fluoroscopic guidance and, in general, follows NCCI guidelines on payment of this procedure. Sentara Health Plan also allows the reimbursement of contrast materials under specific circumstances in accordance with CMS guidelines.

Incident–to Guidelines

Per the CMS National Coverage Provision for Incident-to Services, when non-physician practitioners (NPPs) render services that are incident to a physician's services, they may bill under the physician when the service is:

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

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

There must have been a direct, professional service furnished by the physician to initiate the course of treatment, of which the service being performed by the non-physician is an incidental part, which means that the physician must see the patient first to initiate the plan of care for the

patient. The NPP would follow the physician's plan of care for subsequent services. The physician must perform the initial service for the diagnosis and must remain actively involved during treatment. The physician must perform subsequent services that reflect his or her continued active involvement in the patient's care.

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

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

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

The only time an NPP can bill a service under a physician is when a physician is in the office suite and directly available to help. The physician being available by phone is not appropriate and does not constitute direct supervision. *More information is available from: CMS. (Revised 2016). Incident-to* located **here.**

Behavioral Health Resident in Training & Supervisees

Residents in Counseling and Supervisees in Social Work practice under the license of their clinical supervisor. They can work with all populations for which their supervisor is credentialed. The supervisor shall assume full responsibility for the clinical activities of the board-approved resident, regardless if the supervisor is onsite or offsite, specified within the supervisory contract (application) for the duration of the residency.

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

Billing for these services must be submitted with the supervising provider's individual NPI listed as the rendering provider.

Subrogation

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

Provider And Member Appeals

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

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

Expedited Appeals

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

Standard Appeals

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

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

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

For post-service requests of an adverse decision/denial for payment, please follow the Provider Reconsideration process by completing and submitting a **Provider Reconsideration Form**.

Appeals Process

To start the appeals process, download the **Medicare Appeals Packet** or contact member services.

An appeal must be filed within 65 days of the date on the letter about our initial decision. Sentara Health Plans may give you more time if you have a good reason for missing this deadline. If the member needs someone to act on their behalf to file an appeal, that person must either have legal authority to act on behalf of the member or be appointed as a designated representative by the member. To have a relative, friend, attorney, doctor, or

someone else be appointed as the member's designated representative, both the member and designee must complete, sign, and return the **Appointment of Representative Form** (CMS 1696).

Who may request an appeal:

Expedited Appeal:

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

Standard Pre-Service Appeal:

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

To initiate a Medicare appeal:

1. Mail the Medicare Appeal request to:
   Sentara Health Plans
   Medicare Appeals
   P.O. Box 62876
   Virginia Beach, VA 23466-2876

   Alternatively, you can fax the appeal to 800-289-4970.

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

Adverse Benefit Determination – Provider Appeals on Behalf of a Member

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

Member Assistance With Appeals Related to Medicaid Covered Services

In accordance with 42 CFR 422.562(a)(5), when Sentara Health Plans becomes aware of a member's need for a Medicaid-covered service, Sentara Health Plans will offer to assist members with obtaining Medicaid covered services and resolving grievances, including requesting authorization of Medicaid services, as applicable, and navigating the appeals system.

Medical Records

Practitioners and providers delivering services to Sentara Health Plans members are expected to maintain and appropriately share member health records in accordance with established professional standards.

Practitioners are required to maintain comprehensive and accurate medical records documenting the care and services provided to Sentara Health Plans members. All communications and records related to a member's healthcare must be treated with strict confidentiality. Records may not be released without the member's written consent, or, in the case of a minor, the consent of their legal guardian (unless the records relate to services for which the minor has consented for themselves in accordance with Virginia law).

Members are not required to complete an additional medical release form for Sentara Health Plans to obtain records. Sentara Health Plans may request member records for quality assurance purposes in accordance with state and federal regulations and accreditation standards.

Medical records are essential tools for preserving the continuity, accuracy, and integrity of clinical information. As the primary source of data related to patient care, medical records support not only the treating provider, but also other healthcare professionals involved in coordinating and delivering comprehensive care.

Confidentiality

All medical records are classified as Protected Health Information (PHI) under HIPAA regulations. Any personal information about a member received by the provider from Sentara Health Plans must be treated as confidential and securely maintained within the United States.

Confidentiality of medical records must be upheld through the following practices:

- Secure Storage: Medical records must be stored securely, whether in a confidential filing system or electronically, with appropriate safeguards to ensure that only authorized personnel have access.
- Confidentiality Training: Staff must receive periodic training on the confidentiality of member information, including Sentara Health Plans medical record documentation standards, and additional training as needed.

All provider staff are required to comply with the HIPAA Privacy and Security Rules.

Providers rendering substance use disorder treatment services that are subject to 42 CFR Part 2 must comply with the confidentiality provisions set forth in Part 2.

Medical Record Documentation Standards

Medical records may be audited in accordance with Sentara Health Plans' physical and behavioral health treatment record documentation guidelines which reflect accepted standards for medical record documentation.

Each medical record must include, at a minimum, the following elements:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management & reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care, including:
    - Documentation of collaboration with the member's primary care provider (PCP) regarding medications and treatment, or documentation of the member's refusal to consent
    - Upon obtaining consent for the release of information, the behavioral health provider must notify the member's PCP when the member presents for an initial behavioral health evaluation and for ongoing treatment. This includes communication about significant changes in the member's condition, medication adjustments, and termination of treatment. This applies to all specialty providers.

Medical records must be organized and securely stored in a non-public area that allows for efficient retrieval. Providers are responsible for maintaining well-structured records for all members receiving care and services, ensuring they are readily accessible for review or audit by Sentara Health Plans and designated state, federal, and accrediting entities. Records must be comprehensive and contain sufficient detail to support seamless transfer procedures, promoting continuity of care when members are treated by multiple providers. Patient information should be arranged in a consistent, logical format, either chronological or reverse chronological order, to facilitate clarity and ease of use.

Requests for Medical Records

Sentara Health Plans requires participating providers to make medical records available to the health plan, members, and/or their authorized representatives no later than 10 business days after receiving a request.

Fees for Medical Records:

Participating providers **will not** charge Sentara Health Plans or its members for copies of medical records or for the completion of related forms.

Medical Record Retention and Continuity of Care

Participating providers must retain medical records for Sentara Health Plans members for a minimum of 10 years from the last date of service, or longer if required by applicable Virginia state agency or federal regulations. PCPs are responsible for obtaining and integrating medical records from both participating and nonparticipating providers to whom they refer members,

ensuring continuity and coordination of care.

Medical Record Review and Corrective Action

Providers who do not meet Sentara Health Plans' medical record documentation standards will be required to develop and implement a corrective action plan within a specified timeframe. Each identified deficiency will be monitored at least every six months following the initial review until compliance is achieved. If deficiencies remain unresolved after six months, the matter will be escalated to the Senior Medical Director and/or Credentialing Committee for further review and potential sanctions.

Practice Closure or Sale

Subject to applicable laws, if a provider practice or facility is sold or closed, the provider must notify patients and Sentara Health Plans in writing, indicating the change and the location where patients' medical records will be maintained and stored. Providers must also offer patients the opportunity to obtain copies of their records. In the event of closure, medical records must be retained in accordance with applicable state and federal law.

Monitoring the Quality of Care

Sentara Health Plans collaborates with contracted network and affiliated providers to inspect, audit, review, and obtain copies of medical records related to covered services rendered under each Provider Agreement. These reviews may be conducted for purposes including, but not limited to, benefit determinations, payment decisions, member grievances, quality of care (QOC) reviews, sentinel events, member surveys, internal reports, credentialing monitoring, and other quality improvement initiatives.

To support these activities, Sentara Health Plans and its authorized representatives may request documentation, primarily patient medical records. Providers are expected to submit this information electronically if using an electronic health record (EHR) system, or as paper copies when applicable.

Sentara Health Plans will oversee and review the quality of care administered to members. Providers are encouraged to maintain best practices when documenting a member's medical records.

Medical Record Maintenance Standards

Participating providers must maintain office policies and procedures for medical record documentation that align with the National Committee for Quality Assurance (NCQA) Standards or applicable law. At a minimum, records must be:

- Accurate and legible
- Securely stored to prevent loss, destruction, or unauthorized access (e.g., in restricted non-public areas)
- Organized and accessible for review by the health plan and/or state or federal regulatory entities or external quality review organizations (EQRO)
- Available to Sentara Health Plans' staff, as appropriate, to support quality and utilization management activities
- Comprehensive with sufficient detail to ensure continuity of care when multiple providers are involved

Medical Record Coordination and Continuity of Care Standards

To promote effective communication, coordination, and continuity of care, the following standards must be met:

- A current, legible problem list must be maintained and updated as appropriate. If no significant issues are present, this must be noted (e.g., well-child/adult preventive care visit).
- Allergies and adverse reactions must be clearly documented. If none exists, this must be noted (e.g., sticker or stamp noting allergies or no known allergies (NKA) is acceptable).
- Past medical history must be easily identifiable for all patients, especially patients seen three or more times, and include family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), this includes prenatal care, birth history, surgical history, immunizations, and childhood illnesses.
- Medication records must include drug names, dosages, frequencies, and dates of prescriptions or refills.
- Each page of the medical record must include the patient's name or ID number, and all entries must be dated.
- Working diagnoses and treatment plans must align with clinical findings.
- Consultation reports must be present, with documentation of PCP review and follow-up, and a follow-up phone call must be noted in the PCP's progress note. Electronic consults must show evidence of PCP acknowledgment. Any further follow-up needed or altered treatment plans should be noted in progress notes.
- Continuity and coordination of care must be documented across all providers involved in the member's care, including PCP and specialty providers, hospitals, home health, skilled nursing facilities, and free-standing surgical centers, etc. must be documented when applicable.
- Advance care planning and advance directives discussions must be documented for all adult patients and emancipated minors. If the patient does have an advance directive, it should be noted, and a copy should be present in the medical record.
- Confidentiality must be maintained in accordance with HIPAA and other applicable laws. Records must be stored in secure, non-public areas and accessible only to authorized personnel, health plan staff, state/federal regulatory entities, and anyone else authorized to access such records under HIPAA and state law.
- Substance use assessments (smoking, alcohol, drugs, etc.) must be documented for patients aged 12 and older, with referrals to behavioral health specialists noted as appropriate.
- Preventive screenings must be offered and documented in accordance with Sentara Health Plans' Preventive Health Guidelines and American Academy of Pediatrics and Bright Futures, as applicable, and documented in the progress notes and/or appropriate screening tool.
- To qualify for reimbursement, claims must be supported by medical records that meet requirements in this Manual and all applicable requirements of NCQA, CMS and DMAS.

Advance Directives

Sentara Health Plans provides members with information regarding advance directives, including living wills, healthcare power of attorney designations, and organ donation and anatomical gift preferences. This is done in compliance with the Patient Self-Determination Act

and applicable state laws, which require healthcare providers to inform adult patients of their rights to accept or refuse medical treatment and to create advance directives concerning their care.

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

Additional Guidance

Providers are encouraged to consult their malpractice insurance carrier for any additional requirements or recommendations regarding medical record retention policies.

Provider Communications, Resources, and Appointment standards

Sentara Health Plans encourages our providers to visit our provider site here to research and explore information such as:

- Provider self-service tools
- Medical policies at this link
- Health plan contact numbers
- Billing and claims resources
- Clinical references
- Formularies and drug lists
- Healthcare Effectiveness Data and Information Set (HEDIS®) resources
- Provider update and other forms
- Provider manuals
- Educational materials, such as newsletters and provider announcements
- Access to the Availity provider portal and other secure provider portals

Sentara Health Plans Network Management

The network management department is responsible for keeping our providers up to date on our services and resources, including:

- How to get in network and contract with Sentara Health Plans
- How to update provider demographic information
- Directly addressing any provider's special needs, concerns, or complex situations, credentialing, services, and other requirements
- Provider education and training

Our network educators are assigned to specific providers to directly help navigate products, policy, process, and service updates. The network education team can be reached at contactmyrep@sentara.com.

Provider Portal

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

Throughout 2026, our provider portals, including all features, functionality, and resources, will continue to transition to Availity. This is a phased transition with continued access to the Sentara Health Plans portal. For more information regarding Sentara Health Plans' transition to Availity, click here.

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

For providers new to Availity, the Get Started with Availity page has an abundance of resources and the ability to register the provider's organization.

Provider Notifications

Sentara Health Plans routinely distributes timely notifications via email to provide updates such as:

- Changes to policies and protocols
- Changes to medical policies
- Changes to the provider manual
- Publication of the quarterly provider newsletter
- Details about upcoming educational sessions
- Patient education initiatives
- Quality improvement efforts
- Health plan campaigns
- Other important news and information

Sentara Health Plans notifies providers of any planned policy changes through electronic communications 60 days before the effective date of such policy change. Any pertinent changes to policy and protocols are also communicated with an online provider notice posting. To avoid missing any important updates, providers are required to provide (and update as necessary) a valid email address to Sentara Health Plans via the Provider Update Form or during meetings with the assigned Network Educator.

Provider Trainings

Providers can access both required and encouraged trainings here.

All providers within a provider practice or organization are required to review the Model of Care Provider Guide (MCPG). The MCPG includes important information about the Medicare Special Needs Plans Model of Care. Upon completion of the MCPG training, an attestation must be sent to Sentara Health Plans and can be obtained by accessing this link. If there are multiple providers in a provider practice or organization, only one attestation is required per Tax ID. The attestation must be received and verified by Sentara Health Plans. Once an attestation is received and on file, the training requirement is considered complete for the remainder of the calendar year.

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

Provider Webinars

Online educational webinars are held and allow Sentara Health Plans the opportunity to answer questions from providers, share updates, and offer ideas on how to successfully do business with Sentara Health Plans. Providers must register on the Sentara Health Plans provider website by the day before each event. The events are announced here and in the provider alert email, along with other educational opportunities.

Mailings and Newsletters

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

Telephone

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

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

Managing Provider Contact Information

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

Provider Responsibilities for Excluded Entity Screening and Reporting

The Office of Inspector General imposes exclusions from state and federal healthcare programs under the authority of sections 1128 and 1156 of the Social Security Act. The law requires that no payment is made by any federal healthcare program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Federal healthcare programs are administered by the Centers for Medicare & Medicaid Services (CMS). This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider for which the excluded person provides services, and anyone else who provides services through or under the direction of an excluded person. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Providers are obligated to ensure that Medicaid and Medicare funds are not used to reimburse excluded individuals or entities by taking the following steps:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded. This includes owners with a direct or indirect interest of 5% or more.
2. Search **The Office of Inspector General** website monthly to capture exclusions and reinstatements that have occurred since the last search.
3. Immediately report any exclusion information to Sentara Health Plans in writing.

Civil monetary penalties may be imposed against providers and managed care entities that employ or enter into contracts with excluded individuals or entities to provide services for federal healthcare programs.

HIPAA Privacy Statement

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

Sentara Health Plans maintains compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the American Recovery and Reinvestment Act (ARRA). To ensure the protection of confidential information and patient health information, Sentara Health Plans has implemented privacy and security policies and procedures, has developed required forms, has established safeguards to protect patient health information, and conducts HIPAA awareness training.

Provider Availability: Access and After-hours Standards

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

Providers must make arrangements to refer members seeking care after regular business hours to an appropriate provider. Providers may direct the member to go to an emergency department for potentially emergent conditions, and this may be done via a recorded message.

After Hours Availability Standards

After Hours Standards (Live answer or automated system)	**Standards (Appropriate responses)**
Emergency instructions provided	Caller is directed to hang up and dial 911 or go to the nearest emergency room for life-threatening emergencies.
Process to reach physician	• Directly connects or forwards caller to the physician/on-call physician or appropriate medical professional. • Caller can select an option on their telephone to be directly connected to the physician/on-call physician or appropriate medical professional. • Pages the medical professional; call returned within 30 minutes to the physician/on-call physician or appropriate medical professional. • Answering machines allows caller to leave message; call returned within 30 minutes by the physician/on-call physician or appropriate medical professional. • Call forwarding automatically - call is automatically forwarded to the physician/on-call physician or medical professional.

Appointment access standards for Medicare plans

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

Continuity and Coordination of Care

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

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

A provider shall continue to render health care services, except when the provider is terminated for cause, to any Sentara Health Plans member who has an existing provider-patient relationship:

- For a period of at least 90 days from the date the provider's termination.
- Who is in an active course of treatment from the provider prior to the notice of termination and requests to continue receiving health care services from the provider.
- Who has been medically confirmed to be pregnant at the time of the provider’s termination. Such treatment shall, at the member’s option, continue through the provision of postpartum care directly related to the delivery.
- Who is determined to be terminally ill as defined under §1861 (dd) (3) (A) of the Social Security Act at the time of the provider’s termination. Such treatment shall, at the member's option, continue for the remainder of the member's life for care directly related to the treatment of the terminal illness.
- Who has been determined by a medical professional to have a life-threatening condition at the time of a provider’s termination. Such treatment shall, at the member’s option, continue for up to 180 days for care directly related to the life-threatening condition.
- Who is admitted to and receiving treatment in any inpatient facility at the time of provider’s termination of participation. Such admission and treatment shall continue until the member is discharged from the inpatient facility.

Locum Tenens Providers

The participating provider must notify Sentara Health Plans of the need for coverage by a Locum Tenens provider by submitting a Provider Update Form on the provider website. In emergency/urgent cases, notification should be made prior to the Locum Tenens provider providing services to Sentara Health Plans members. All services performed by the Locum Tenens provider should be billed with the Locum Tenens provider's NPI number. Since the Locum Tenens provider status is as a covering provider, Locum Tenens providers will not be listed in provider directories, on the provider website, or on listings of participating providers for reporting purposes.

Physician Assistants and Nurse Practitioners

Physician Assistants, Advanced Practice Registered Nurses (including Licensed Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives and Certified Nurse Anesthetists) may contract with Sentara Health Plans to provide covered services in accordance with the state law applicable to advanced practice providers.

Nurse Practitioners and Physician Assistants who are under contract with Sentara Health Plans will be reimbursed for services provided to Sentara Health Plans members provided:

- They are participating with Sentara Health Plans under an active Provider Agreement (either directly or from a group affiliation).
- They are operating within their license – meaning if their license requires them to be supervised, they meet criteria for supervision.
- The services they provide are covered and proper authorizations are in place.

Physician Assistants and Nurse Practitioners as PCPs

Physician Assistants and Nurse Practitioners who are willing and able to meet the Primary Care Provider requirements and obligations stated in the Sentara Health Plans Provider Agreement may, upon request, provide Primary Care services to members that are assigned directly to them as their Primary Care Provider for all Sentara Health Plans Medicare Advantage Products. This does not apply to Medical and Behavioral Health Nurse Practitioners who only provide specialty care services.

For new practices or existing practices, a Provider Update Form must be submitted to credential the Physician Assistant or Nurse Practitioner as a PCP with assigned members.

Physician Assistants and Nurse Practitioners that are approved by Credentialing as PCPs will be set up with an open panel status to be eligible for incentives available to PCPs based on their attributed members. They will be set up to appear in provider directories as PCPs.

If the Physician Assistant or Nurse Practitioner is working under a Practice Agreement in collaboration with a licensed patient care team physician, the Physician Assistant's or Nurse Practitioner's participation cannot be effective prior to the licensed patient care team physician's effective date of participation.

Compliance/Ethics

Confidentiality

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

Program Integrity

Sentara Health Plans' Program Integrity Unit (PIU) has a fiduciary responsibility to protect our members and plays a crucial role in maintaining the integrity of Sentara Health Plans. The Program Integrity Unit is a dedicated team that focuses on detecting, resolving, and preventing potential fraud, waste, and abuse (FWA) by analyzing claims data, monitoring trends, and conducting in-depth investigations to uncover suspicious activities and unusual patterns of potential abusive behavior. The Program Integrity Unit's efforts not only help safeguard financial resources but also ensure that care and coverage remain accessible to those who truly need it.
The Program Integrity Unit has documented its efforts to detect, resolve, prevent, and report potential fraud, waste, and abuse by implementing an Anti-fraud Plan to ensure compliance with state and federal regulations.

To read more about Sentara Health Plans' Anti-Fraud Plan, click here.
To report possible fraud, waste, or abuse, please utilize the following options:

Hotline:

- (757) 687-6326 or (866) 826-5277
- Available 24 hours a day, 7 days a week. This is a voicemail service only; someone will contact you within 48 hours.

Email:

- compliancealert@sentara.com

All referrals made to the Program Integrity Unit (PIU) will remain anonymous. Please be sure to leave your name and number if you wish to be contacted to follow up.

Business Information

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

Equal Opportunity Employment

Pursuant to Section 503 of the Rehabilitation Act of 1973, as amended, and the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, you are advised that our subcontractors, suppliers, and vendors are obligated to take affirmative action to provide equal employment opportunity without regard to disability, and/or veteran status.

Conflict of Interest

Sentara Health Plans' employees may not accept:

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

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

Anti-Kickback Statute

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

Business Records

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

Billing Practices

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

Government Sanctioning

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

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

Maintaining Your Position of Trust

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

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