Good Afternoon
Thank you for waiting while we gather.

2nd Quarter Let's Talk Behavioral Health

May 13, 2025

Sentara®
Health Plans

Agenda

1. **Sentara Health Plan Behavior Health Utilization Management Provider Updates- Cindy Hobbs, RN, MS- Director, Behavioral Health UM**

2. **Behavioral Health Redesign – Kresha Garland, PsyD, MBA|CCM|CCMC, Director Behavioral Health Contracting, LTS & SCAs**

3. **What's New at Sentara Health Plans in 2025**

4. **Member Experience**

5. **DMAS Updates/Follow-up**

6. **Billing Reminders, Authorization Updates and Important Reminders**

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BH UM Gov Updates

Improvements and Updates for Community Providers

Process Improvements: Registration Requests

•Faster Turnaround Times

- Streamlined registration process
- Reduced approval wait times

Faxed Authorization Request Processing

•Improved Accuracy

- Enhanced shelling request protocols
- Faster processing times

New Provider Portal

•Launch Date: Q3 2025

- Simplified authorization request process
- User-friendly interface

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Important Changes Impacting Providers

ARTS Authorization Review

•Decreased Approval Times

- Higher levels (including residential): 3-7 days
- Lower levels: 7-30 days

•Goals

- Better oversight of member progress
- Quick adjustments for identified gaps

Crisis Services Reminder

•PRN File Usage

- Directed by DMAS for correctly licensed providers
- SHP will not approve crisis services for providers not on the PRN file

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Authorization Submission Requests

Discharge Planning Updates

•Include Discharge Summaries

- Ensure all discharge summaries are sent to us
- Send SHP updates towards discharge planning in clinical documentation

IP BH Requests

•Facility NPI#

- Include the facility's National Provider Identifier (NPI) number

ARTS Requests

•Required Information

- Date of last use
- Frequency of use
- Updated drug screens

Key Submission Requirements

•Dates and Units

- Ensure accurate dates and units are provided

•Avoid Copy-Pasting

- Provide detailed, specific information
- Avoid fluff, but ensure justification is thorough

•Attachments

- Include all promised attachments
- Attach ABA schedules

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Authorization Submission Requests – cont.

Behavioral Information

•Frequency, Intensity, Severity

- Highlight behaviors in the last 30 days
- Include both improvements and lack of improvement

Care Coordination

•Discharge Planning

- Emphasize discharge planning and future support
- Community mental health should focus on treatment goals

Additional Requirements

•Fax Confirmation Sheets

- Include to avoid denial for untimely submissions

•Correct NPI Number

- Ensure the NPI number is accurate

•Discharge/Transition Plan

- Provide an estimated date of discharge

Review Denial Letters

•Authorized Dates and Units

- Check denial letters carefully for authorized dates and units

Linkage to OPT for IIH

•Care Coordination Documentation

- Document care coordination monthly
- Prepare for discharge or provide rationale for continued services

CCR Submissions

•Review Previous Authorizations

- Submit for partially approved or lower units
- Link member to PA recommendations and document efforts

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Questions?

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Let's Talk Behavioral Health
"Behavioral Health Redesign – Regulatory Update Reminder

Kresha Garland, PsyD

Director, Behavioral Health Contracting, LTSS & SCAs

May 13, 2025

Transforming Behavioral Healthcare for Virginians

Behavioral Health Redesign – *TRANSFORMATION*

In December 2022, Governor Youngkin announced a **six-pillar plan** to transform Virginia's behavioral health system: the Right Help, Right Now. Plan. (RHRN). As plans developed, initiatives to redesign Medicaid legacy community mental health rehabilitative services (CMHRS) emerged as significant needs within the system. The legacy CMHRS services include:
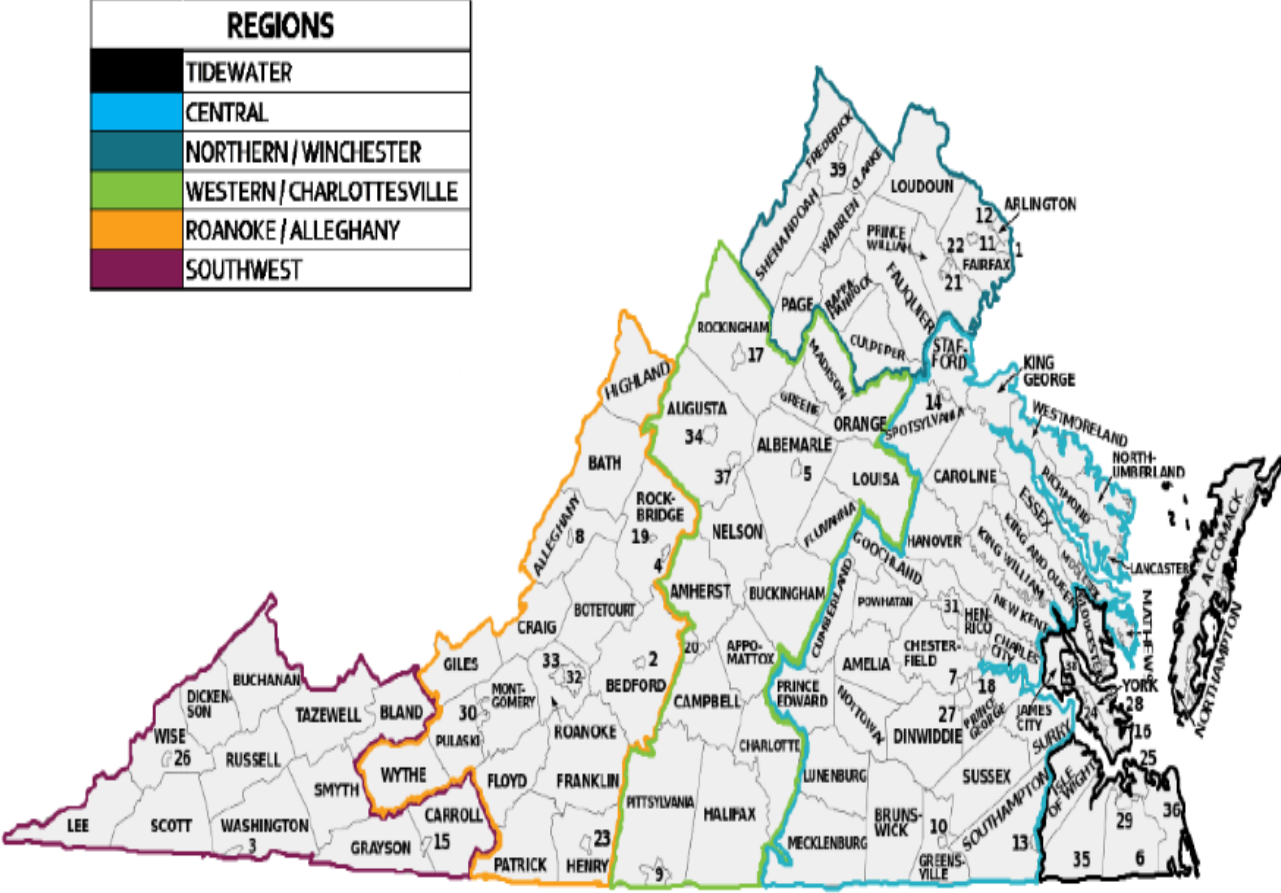
- **Intensive In-Home (IIH)**

- **Therapeutic Day Treatment (TDT)**

- **Mental Health Skill Building (MHSS)**

- **Psychosocial Rehabilitation (PSR)**

- **Mental Health Case Management for both adults and youth (MHCM)**

In collaboration with the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Health Professions (DHP), DMAS launched a two-year project (July 2024-June 2026) to replace our CMHRS services and case management service.

Behavioral Health Redesign – PURPOSE

Transforming Behavioral Health: Right Help, Right Now

"Governor Glenn Youngkin's Right Help, Right Now plan ensures Virginians get immediate behavioral health support before, during, and after a crisis. **By expanding 988, mobile crisis units, and crisis centers, it improves care for children, adults, and families, reduces emergency department strain, and supports law enforcement.** The plan will also strengthen substance use disorder treatment and mental health services, positioning Virginia as a leader in behavioral health reform."

REGIONS	
⬛	TIDEWATER
🟦	CENTRAL
🟦	NORTHERN / WINCHESTER
🟩	WESTERN / CHARLOTTESVILLE
🟧	ROANOKE / ALLEGHANY
🟪	SOUTHWEST

Behavioral Health Redesign – *Timeline: July 2024 – June 2026*

Year 1

Year 2

July 2024-June 2025

- Service research, stakeholder input, contractor support to develop service requirements
- Develop service definitions and requirements
- Develop FFS rates for each proposed new service
- Estimate utilization, cost and budget impact for redesigned services

July 2025-June 2026

- Operationalize new services through licensure, regulatory, and policy manual changes
- Prepare providers to transition to new services
- Ensure MCO readiness to implement new services
- New Services Go Live
  Potential phased in approach of service implementation

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Behavioral Health Redesign – UPDATES

Updates regarding Behavioral Health Redesign will be communicated to participating providers via the SHP providers alerts, newsletters, and website upon receipt. Additional information can also be obtained via the DMAS website: DMAS website: https://www.dmas.virginia.gov/for-providers/benefits-services-for-providers/behavioral-health/medicaid-behavioral-health-services-redesign/.

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What's New at Sentara Health Plans in 2025

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Vendor Implementations

Zelis Payments Network (ZPN) Partnership became Effective March 3, 2025

Please note that Sentara Health Plans (SHP) will continue to release payments for processing daily. Funds availability for Medicaid and Medicare will be determined by the time they are received by Zelis.

SHP will strive to have all payments processed prior to 11:30 a.m. EST (10:30 CST) to ensure timely payment. **Remittances will now be offered through Zelis Payments**. Remittances will no longer be available through Payerpath or Payspan, and **only** historical remittances will be available through Provider Connection (the SHP portal)

To register for Zelis Payments Network or Sentara Health plans epayment visit our website; EFT/ERA Authorization Agreement Instructions | Providers | Sentara Health Plans

OncoHealth Implementation Effective March 4, 2025

Our partnership with OncoHealth® to administer Sentara Health Plans Oncology Benefits Management Program became effective on March 4, 2025. OncoHealth will support prior authorization management of all Sentara Health Plans commercial, Medicaid, and Medicare lines of business. OncoHealth will also provide Oncology Case Management for Sentara Health Plans' members through their Iris platform.

Authorization requests can be submitted through the Sentara Health Plans provider portal or directly through OncoHealth's OneUM® portal.

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Provider Portals
Availity Essentials and Sentara Health Plans Portal

Sentara Health Plans partnership with Availity Essentials began on January 1, 2024. To ensure Sentara Health Plans provides the best user experience, some Availity Essential features will be implemented throughout the year. Current features are listed below for Availity and Sentara Health Plans Portal.

Availity Essentials access: <u>Essentials Registration & Support | Availity</u>

- Claims Submission
- Remittance Viewer
- Eligibility & Benefits – **Now Available Member ID Card View**
- Claims Status
- Payer Space
  - Access helpful resources such as payment policies, views our newsletters and important updates/announcements.
  - Connect to the Sentara Health Plans Portal to conduct transactions not yet available in Availity Essentials. Features available:
    - **Sentara Health Plans Portal access**: claims status, eligibility & benefits, remittance viewer, payment policies, authorizations and claims corrections. Need to Register: <u>Provider Connection | Sentara Health</u>. FAQs: <u>Provider Connection Registration | Providers</u>. If you need assistance with Provider Connection email <u>providerconnectionsupport@sentara.com</u>. For features no longer available effective 6/15/2025 in the Sentara Health Plans Portal refer to the Provider Alert dated April 15, 2025, <u>Provider Alert: Portal Features Update and OncoHealth Authorization Submission | Sentara Health Plans</u>
    - To submit reconsiderations for Medicare and Medicaid lines of business, login or register: **<u>Sentara Health Plans Provider Portal | Login (payertransactions.com)</u>**

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Member Experience

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Welcoming Baby

Welcoming Baby^{SM} is an incentive-based program that provides Sentara Health Plans Medicaid members with a variety of clinical and personal resources and ongoing support during and after pregnancy. We host baby showers throughout the year. Please share website information with Sentara Health Plans Medicaid members to they can locate the next convenient date. Baby Showers | Sentara Health Plans

Medicaid members now have access to view the following online:

- frequently asked questions

- maternal health benefits

- education and events and resources

The Sentara Health Plans health and wellness page now provides a link to our maternal health programs:

- Welcoming Baby for Medicaid members

- Partners in Pregnancy for commercial and Medicare members

Welcoming Baby:

Welcoming Baby | Medicaid | Sentara Health Plans

Maternal health:

Maternal Health Benefits | Medicaid | Sentara Health Plans

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DMAS Updates/Follow-up

DMAS Updates

Manual Updates

- **Rehabilitation Manual, Appendix D (Service Authorization)** [Updates to Rehabilitation Manual, Appendix D (Service Authorization) | MES](#)

- **All provider manuals, Chapter 3 (Member Eligibility)** [Updates to All Provider Manuals, Chapter 3 (Member Eligibility) | MES](#)
  -
- **BabyCare Provider Manual Chapters 2 & 4** [Updates to BabyCare Provider Manual Chapters 2 and 4 | MES](#)

  [Memo & Bulletin Library | MES](#)

Memo Updates

- **Per Diem Inpatient Billing for Psychiatric and Rehabilitation Services – Effective February 11, 2025.** [Per Diem Inpatient Billing for Psychiatric and Rehabilitation Services – Effective February 11, 2025 | MES](#)

- **Virginia Medicaid Preferred Drug List/Common Core Formulary and New Drug Utilization Board Approved Drug Service Authorizations Effective April 1, 2025** [Virginia Medicaid Preferred Drug List / Common Core Formulary and New Drug Utilization Board Approved Drug Service Authorizations Effective April 1, 2025 | MES](#)

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Billing Reminders, Authorization Updates & Important Reminders

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Payment Policies

Payment Policies are in Availity under Payer Space, [Essentials Registration & Support | Availity](#)

Payment Policy: Modifier 25 Payment Policy

Policy Number: 4367

Version Number: 2

Form(s): 1500, UB-04

Modifier 25 Payment Policy-Medicare

Payment Policy Disclaimer

Payment policies serve as a guide to assist with accurate claim submission. You are responsible for the submission of accurate claims information to Sentara Health. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or Revenue codes with appropriate ICD-10 diagnosis. The codes shall denote the services and/or procedures performed. Subject to applicable law, if appropriate coding/billing guidelines or current payment policies are not followed, Sentara Health may reject/deny the claim or recover and/or recoup claim payments.

The payment policies do not cover all issues related to reimbursement for services rendered to Sentara Health enrollees. Further, legislative mandates, the physician or other provider contract documents, the enrollee's benefit coverage documents, and the Provider Manuals all may supplement or, in some cases, supersede these payment policies.

Sentara Health payment policies may use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Uniform Billing Committee (NUBC), or other coding guidelines to determine appropriate payment. The payment policies apply to all health care services billed on CMS 1500 forms and UB04 forms. Additionally, Sentara Health payment policies apply to both participating and non-participating professionals and facilities, unless otherwise indicated. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing payment policies.

Sentara Health reserves the right to review and revise payment policies when necessary. The most current version of this payment policy will be published on the website. For clarity, payment policies apply to claims processed pursuant to Sentara Health Plans provider contracts.

Billing Reminders

Primary COB for Dual eligible Members (DSNP)

- When submitting claims for members with both Medicare and Medicaid always file Medicare as primary. Doing so will avoid processing delays. Claims must include the member's Medicare ID number. Following this process allows our team to process these claims in a timely manner. If the claim is not filed with the Medicare number first it will be denied D95 stating the provider needs to resubmit with Medicare number.

Important Reminder About the National Provider Identifier for Groups

- When requesting an authorization for a provider within a group, please verify that the National Provider Identifier (NPI) on the request matches the NPI listed on the claim for the group (i.e. durable medical equipment, hospital, etc.). The additional step of ensuring NPIs match will help prevent the inappropriate denial of claims.

Carefully Review All Claims Before Submission

To avoid denials, incorrect payment, and delays in processing claims it is critical that the rendering provider, DOS and services on the authorization match with the dates of service and services provided on the claim before submission.

# Authorization Turnaround Times & Important Reminders

Once you have submitted your authorizations the **turnaround times** for your request to be completed are as follows:

- Non-emergent – 14-day turnaround time
- Urgent requests – 72-hour turnaround time

We ask that you do not contact Provider Services prior to these times. You can check the status of your authorizations through the Sentara Health Plans Provider Portal by going into the Create/View Authorizations which will take you to the JIVA portal where you can view all authorizations for your office or by member.

Important Reminder:

- Please enter information in the contact fields of the authorization (email addresses, name, and phone number) this will enable someone from the utilization management team to contact you if there are any questions.
- When you see Drafts in your dashboard this means the authorization is incomplete and will need to be completed.
- Please ensure you are finishing the authorization and clicking OK for your confirmation. If you do not this prevents the utilization management team from being able to process the request.
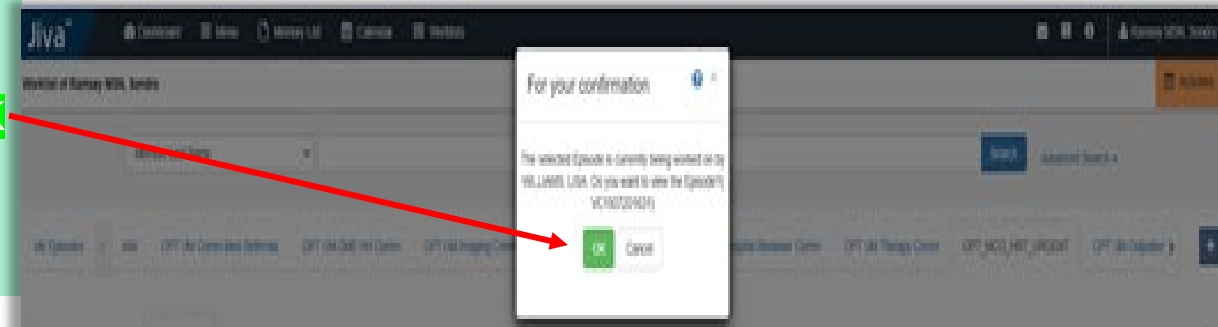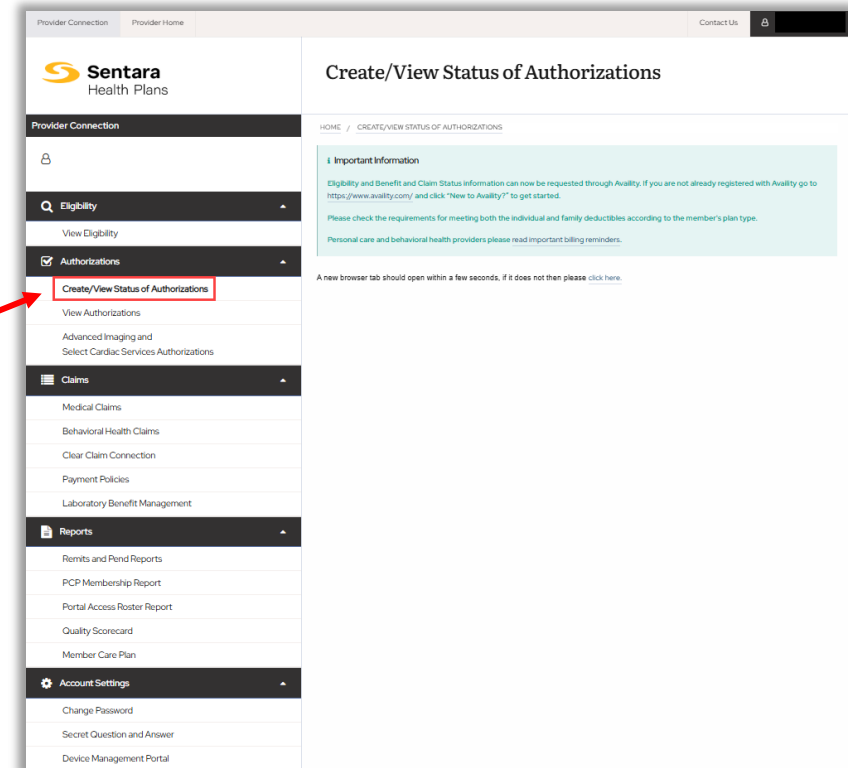
Prior Authorization Tool (PAL)

Sentara's Health Prior Authorization List (PAL) is used to determine authorization requirements for Medicaid, Medicare, Commercial Fully Insured and Exchange Plans. **Does not include self-funded groups**. It is accessible via Payer Space under Resources in Availity and under the Authorizations tab on the Sentara Health Plans Website. [Authorizations | Providers | Sentara Health Plans](#)

Note:

- Key changes in authorization requirements are updated on our website at https://www.sentarahealthplans.com/providers/authorizations/update-reports

- Providers will not be required to obtain an authorization for certain medical supplies or services when the request does not exceed certain limits.

- Details regarding limits will be noted in the Exceptions column of the Prior Authorization List.

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Behavioral Health Authorization Forms for Inpatient and Outpatient Care

To expedite review and provide your patient's with timely access to care, please use the new [Behavioral Health Inpatient Authorization Request for Medicare and Medicaid](#) and [Behavioral Health Outpatient Authorization Request for Medicare and Medicaid](#) forms located on our [website](#). The new forms require that clinical notes are attached for review. Submission of the new form eliminates the need to contact your office to request the documentation required

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Access to Care Protocol & Appointment Access Standards

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

Sentara Health Plans Commercial and Medicare Provider Manual on page 13 and page 14.

Sentara Health Plans Medicaid Provider Manual on page 69 through page 71.

[Provider Manuals and Directories | Providers | Sentara Health Plans](#)

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Reimbursement for Services Rendered While Credentialing is Pending

No services shall be provided to a Sentara Health Plans member until a completed credentialing application has been received by the health plan. Claims for these services must be held until you have received notification of credentialing approval, and your Provider Agreement is signed by Sentara Health Plans. This Provider Agreement must be fully executed for these claims to be processed. If a Sentara Health Plans Provider Agreement is not signed and/or you do not meet all credentialing requirements, Sentara Health Plans is not required to reimburse your claims as a network provider, and you should not seek any reimbursement for services provided to the member from the time of application to final notice of the credentialing decision. [Provider Manuals and Directories | Providers | Sentara Health Plans](#), Page 9

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Provider Trainings

Required Annually

❖ Model of Care

[Provider Education | Providers | Sentara Health Plans | Sentara Health Plans](#)

Encouraged
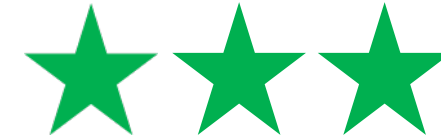
❖ Cultural Competency Training

❖ Trauma Informed Care Training

❖ Fraud Waste and Abuse

Model of Care Guide

Model of Care Attestation

Provider Changes and Updates – 60 days notice

60 days notice is required for all changes.

Submit the following changes by completing the **Provider Update Form** located at
[Update Your Information | Providers | Sentara Health Plans | Sentara Health Plans](#)

➢Panel Status/Accepting new patients
➢Contact information (address, phone, email, etc. – for all locations)
➢Provider relocation or joining additional practice
➢Tax ID change (need a new/current W-9)
➢Name change
➢Practitioner leaving practice/deceased

Directly Notify your contract manager of the following:

➢**Tax ID change (need a new/current W-9)**
➢Name change

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Important - Providing the BEST E-mail Address(es)...

- Ensures you receive notification of changes 60 days or more in advance
- Allows you to prepare <u>early</u>
- Allows to you ask questions <u>prior</u> to implementation
- Helps avoid unnecessary denial of claims, claims reprocessing, etc.
- Allows you to participate in provider trainings in advance of changes, when offered

Who Needs to Know?

- Practitioners (physicians, nurses, other clinicians)
- Billers and coders
- Practice administrators/managers
- Quality subject matter experts

Note: If you are the designated recipient, be sure to forward to others as appropriate. Be sure to update your contacts and email addresses when staffing changes occur (including role changes).

Online Provider Update Form and Applications

- When submitting the online Provider Update Form and Applications, be sure they are being filled out completely. We are finding that notes are being made in the comments instead of completing the entire form. Filing out the forms completely will assist in a quicker turnaround time for the applications and the updates can be processed in a timely manner.

PRSS Enrollment

- All Medicaid managed care network providers must enroll through Provider Services Solution (PRSS) to satisfy and comply with federal requirements in the 21st Century Cures Act. In order to be a Medicaid provider in an MCO's network you must first enroll through PRSS and then contact the MCO(s) you wish to participate in to ensure each MCO's requirements are satisfied.
- Visit Home (https://virginia.hppcloud.com)

Provider Connection – Requesting Access for New Providers

- Before Provider Connection access can be granted to new providers the completion of loading provider information must be done to have the accounts available to link to the user's portal profile.
- Providers are sent an auto email completion message notifying of credential approval, when they are loaded, and that they can submit a provider connection portal request. Submitting requests prior to notification causes high volumes of requests and delays.

Claims Project Request Template

Please Note: When completing the claims project template, **the claim number MUST** be included. The inclusion of the claim number ensures that the claims project team can work more efficiently to complete your request. The template should not be used to submit open AR claims.

Report Critical Incidents

A critical incident is defined as any actual, or alleged, event or situation that creates significant risk of substantial or serious harm to the member's physical or mental health and safety or well-being of a member/patient.

Immediately report alleged abuse, neglect or exploitation related critical incidents to appropriate protective services agency: Contact:

- Adult Protective Services (APS): (888) 832-3858
- Child Protective Services (CPS): (800) 552-7096

Within **24 hours**, Email: **criticalincidents@sentara.com**; OR fax Critical Incident Report form to Fax: (833) 229-8932 located at Critical Incident Form_11092021 (sitecorecontenthub.cloud) **OR** Call Sentara Health Plans: (757) 252-8400

Helpful Links & Key Contacts

Email Addresses & FAQs

Request for Participation Forms: PRVRECRUIT@sentara.com

Provider Update Form Follow-Up: PUStatus@sentara.com

Credentialing Status Follow-Up: SHPCredDept@sentara.com

Recredentialing Status Follow-Up: SHPRecred@sentara.com

Connect With Your Network Educator: contactmyrep@sentara.com

Frequently Asked Questions: Frequently Asked Questions | Providers | Sentara Health Plans

EFT/ERA Set up

Zelis Payment Network (ZPN): Please call 1-855-496-1571 or visit Enroll in a Zelis Network or Sign-up for Consolidated e-Payments

Zelis' Sentara's ePayment Center: please call - 855-774-4392, login or register for basic EFT/ERA at // sentarahealthplans.epayment.center *(copy and paste into web browser)*

Provider Portal Registrations & Support

Availity Essentials: Essentials Registration & Support | Availity. Provider Support contact: 1-800-282-4548

Sentara Health Plans Portal: Provider Connection | Sentara Health. Provider Support contact: providerconnectionsupport@sentara.com

Sentara® Health Plans

Register for Upcoming Webinars

Sentara Health Plans Spotlight
Sentara Health Plans Spotlight on Recent Milestones, Changes and Updates
September 23, 2025 – 1 PM   October 1, 2025 – 10 AM

Let's Talk Behavioral Health
August 12, 2025 – 1 PM

Claims Brush-up
June 18, 2025

Provider Quality Care Collaborative
June 4, 2025 – 12 PM   July 2, 2025 – 12 PM

Questions?

Thank you for Partnering with
Sentara Health Plans

Contact Us

CONTACTMYREP@sentara.com

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Give us your feedback

Let's Talk Behavioral Health

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