1st Quarter Let's Talk Behavioral Health

February 11, 2025

Sentara® Health Plans

Agenda

1. What's New at Sentara Health Plans in 2025
2. Member Experience
3. DMAS Updates/Follow-up
4. Billing Reminders, Authorization Updates and Important Reminders
5. Sentara Health Plan Behavior Health Utilization Management Provider Updates- Cindy Hobbs, RN, MS- Director, Behavioral Health UM
6. Behavioral Health Updates – Thomas Bateman, Clinical Implementation Manager Government Behavioral Health & Randy Hoffman, Network Relations Manager, Contracting

What's New at Sentara Health Plans in 2025

Vendor Implementations

Zelis Payments Network (ZPN)

Provider payment processing is transitioning to the Zelis Payments Network. If you are already enrolled in the Zelis Payments Network, no further action is needed to continue receiving electronic payments. You will begin receiving claim payments from Sentara Health Plans via your preferred payment method and under the same terms currently established with Zelis. If you have any questions or want to change your payment method, please call 1-855-496-1571 or visit Enroll in a Zelis Network or Sign-up for Consolidated e-Payments.

If you do not want your Sentara Health Plans payments to flow through your current Zelis Payments Network solution, other options are available. You may enroll in the Sentara Health Plans ePayment center for basic electronic funds transfer (EFT) and electronic remittance advice (ERA) services at no cost. To enroll in Sentara's ePayment Center please call - 855-774-4392 // help@epayment.center or click Sentara Health Plans

Historical remittances can still be accessed through the Sentara Health Plans Portal.

OncoHealth Implementation Rescheduled to March 4, 2025

OncoHealth® to administer Sentara Health Plans Oncology Benefits Management program was rescheduled for implementation effective March 4, 2025. OncoHealth will also provide Oncology Case Management for Sentara Health Plans' members through their Iris platform. **The suspension of the prior authorization requirement for medical oncology drugs and radiation therapy by Sentara Health Plans will end on March 3, 2025.** Prior authorizations for members with a cancer diagnosis that requires chemotherapeutic drugs (oral and infusion), CAR-T, pharmacy benefit oncology drugs, radiation therapy, and molecular genetic testing should be submitted to OncoHealth beginning on March 4. The impacted codes will be viewable in the Prior Authorization List (PAL) on the same date.

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: Essentials Registration & Support | Availity

- Claims Submission
- Remittance Viewer
- Eligibility & Benefits – **Now Available**
- Claims Status **– Now Available**
- 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, member ID card views, payment policies, authorizations and claims corrections. Need to Register: Provider Connection | Sentara Health. FAQs: Provider Connection Registration | Providers. If you need assistance with Provider Connection email providerconnectionsupport@sentara.com.
    - To submit reconsiderations for Medicare and Medicaid lines of business, login or register: **Sentara Health Plans Provider Portal | Login (payertransactions.com)**

Medicare telehealth coverage in 2025

Effective January 1, 2025, Sentara Health Plans will cover approved benefit services that are included on the Centers for Medicare & Medicaid Services (CMS) fee schedule when billed using the appropriate CPT or HCPCS code.

For details, visit Home - Centers for Medicare & Medicaid Services | CMS and download the **CY 2025 PFS Final Rule List of Telehealth Services** information.

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

Member Experience

Welcoming Baby

Welcoming Baby℠ 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

DMAS Updates/Follow-up

DMAS Updates

Manual Updates

Plan First Program Changes – Chapter IV. For more information; Plan First Program Changes Chapter IV | MES

Psychiatric Services Manual – Updates to Service Authorization Appendix C. For more information; Updates to the Service Authorization Appendix (Appendix C) of the Psychiatric Services Manual | MES

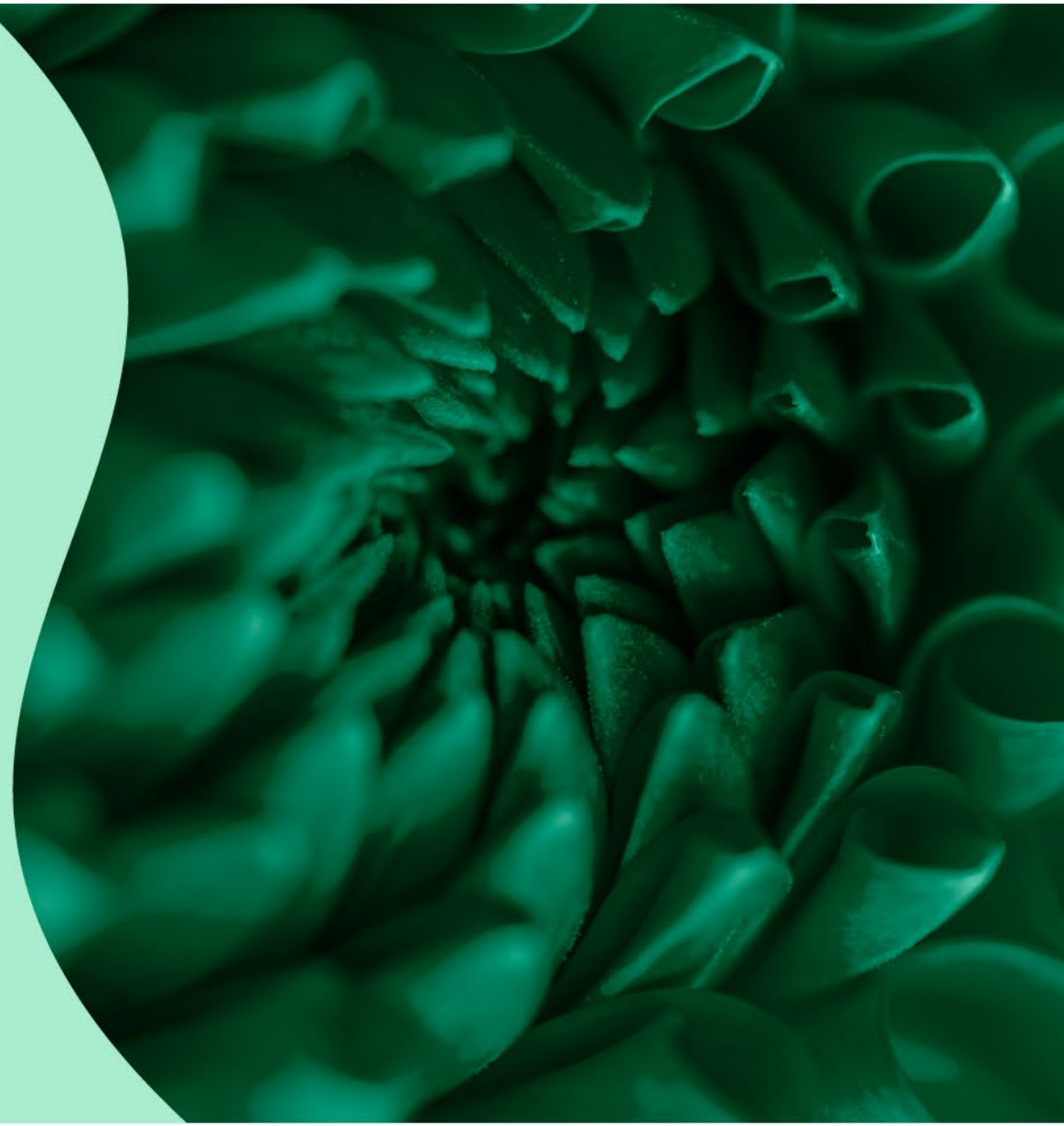
Mental Health Services Manual – Updates to the Intensive Community Based Support Appendix E. For more information; Updates to the Intensive Community Based Support Appendix (Appendix E) of the Mental Health Services Manual | MES

Memo & Bulletin Library | MES

Memo Updates

- **Third Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications.** DEA and HHS have issued a third temporary extension of the telemedicine flexibilities that will expire on December 31, 2025. For more information; Third Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications | MES
- **Updates to Brain Injury Services Targeted Case Management Supplement.** DMAS Memo dated 2/3/205 updates added FAMIS/CHIP members as recipients for the service and allows providers licensed by DBHDS for case management services become providers for Brain Injury Case Management. For more information: Updates to Brain Injury Services Targeted Case Management Supplement | MES
- **Virginia Medicaid Preferred Drug List/Common Core Formulary and New Drug Utilization Board Approved Drug Service Authorizations Effective January 1, 2025.** For more information; Virginia Medicaid Preferred Drug List / Common Core Formulary and New Drug Utilization Board Approved Drug Service Authorizations Effective January 1, 2025 | MES
- **Consumer-Directed Work Shift Submission Requirements, Effective January 1, 2025.** For more information; Consumer-Directed Work Shift Submission Requirements, Effective January 1, 2025 | MES

Billing Reminders, Authorization Updates & Important Reminders



Payment Policies

Payment Policies are in Availity under Payer Space, Essentials Registration & Support | Availity or in the Sentara Health Plans Portal, Provider Connection | Sentara Health.

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

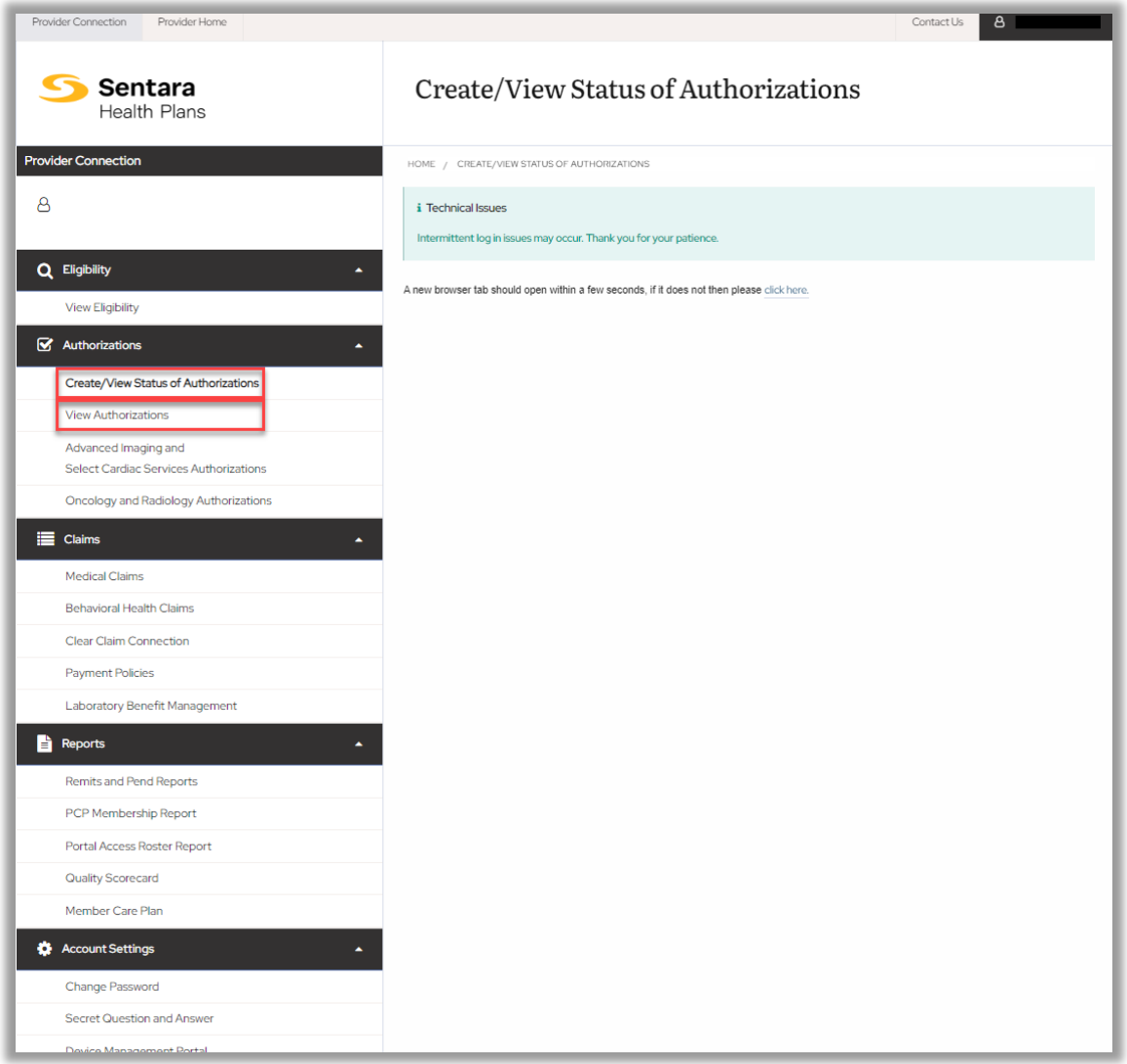
- When requesting an authorization for a provider within a group, please verify that the National Provider Identifier (NPI) on the request matches the NPI listed on the claim for the group (i.e. durable medical equipment, hospital, etc.). The additional step of ensuring NPIs match will help prevent the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

Authorization Turnaround Times

We have been notified by Provider Services that providers are contacting the team about authorizations too soon after they have been submitted. As a reminder the turnaround times 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 legacy 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. You can also go into the View Authorizations in the legacy Optima Health Portal.



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.

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

Reimbursement for Services Rendered While Credentialing is Pending for Commercial Plan

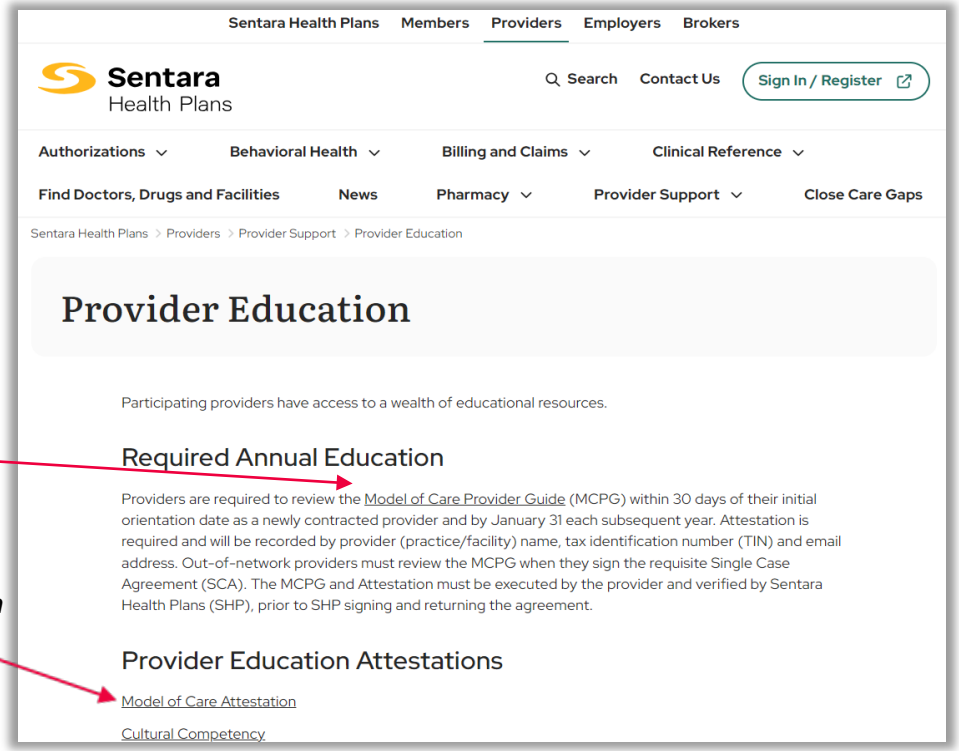
In accordance with § 38.2-3407.10:1 of the Code of Virginia, as applicable, Sentara Health Plans may reimburse new provider applicants for services rendered during the period in which their credentialing application is pending. An application is considered pending once the application has been deemed complete/clean by Sentara Health Plans to advance within the credentialing process. Reimbursement for services rendered during the pending application period is contingent upon approval of the new provider applicant's credentialing application by Sentara Health Plans Credentialing Committee. If the new provider applicant is not approved, any claims submitted for services rendered during this period will be denied, and the provider is prohibited from collecting any amount for these services from the member. Please review this section in its entirety in the Sentara Health Plans Commercial and Medicare Provider Manual. Provider Manuals and Directories | Providers | Sentara Health Plans

Provider Trainings

Required Annually

- Model of Care

[Provider Education | Providers | Sentara Health Plans | Sentara Health Plans]



Model of Care Guide

Model of Care Attestation

Encouraged

- Cultural Competency Training
- Trauma Informed Care Training
- Fraud Waste and Abuse

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

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

- Ensures you receive notification of changes 60 days or more in advance
- Allows you to prepare early
- Allows to you ask questions prior 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

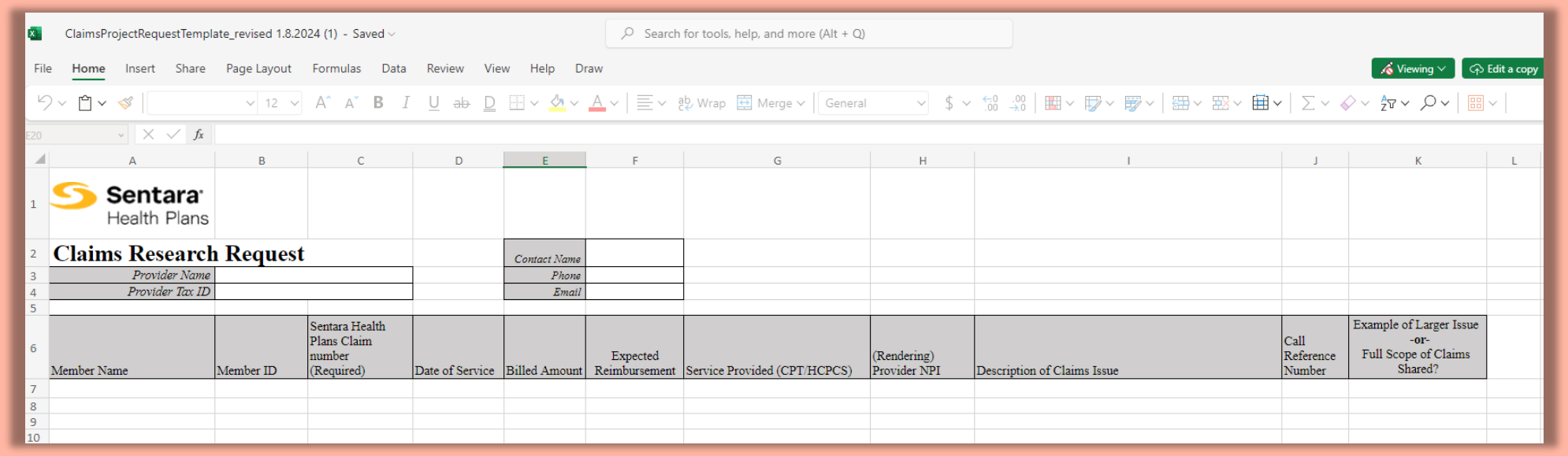
- All Medicaid managed care network providers must enroll through Provider Services Solution (PRSS) to satisfy and comply with federal requirements in the 21st Century Cures Act. In order to be a Medicaid provider in an MCO's network you must first enroll through PRSS and then contact the MCO(s) you 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.



ClaimsProjectRequestTemplate_revised 1.8.2024 (1) - Saved

Search for tools, help, and more (Alt + Q)

File Home Insert Share Page Layout Formulas Data Review View Help Draw

Viewing Edit a copy

Sentara Health Plans

Claims Research Request

Provider Name	
Provider Tax ID	

Contact Name	
Phone	
Email	

Member Name	Member ID	Sentara Health Plans Claim number (Required)	Date of Service	Billed Amount	Expected Reimbursement	Service Provided (CPT/HCPCS)	(Rendering) Provider NPI	Description of Claims Issue	Call Reference Number	Example of Larger Issue -or- Full Scope of Claims Shared?

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

Register for Upcoming Webinars

Sentara Health Plans Spotlight
Sentara Health Plans Spotlight on Recent Milestones, Changes and Updates
February 25, 2025 – 1 PM March 5, 2025 - 10 AM

Let's Talk Behavioral Health
May 13, 2025 – 1 PM

Claims Brush-up
March 12, 2025

Provider Quality Care Collaborative
March 5, 2025 – 12 PM April 2, 2025 – 12 PM

Sentara®
Health Plans

Sentara Health Plan Behavior Health Utilization Management Provider Updates

BH UM Housekeeping items:

1. Reminder to include demographic information on your authorization submission forms to streamline the ability to confirm HIPAA for the member you are requesting services on.

Such as:

1. Member Plan ID Number
2. Date of Birth
3. Medicaid/Medicare ID Number
4. Members Address
5. Members Telephone Number
6. Social Security Number

Along with the member's name, we need two other items to match to proceed with the authorization review.

2. Submit discharge summaries/notifications promptly so critical case management activities can be triggered and additional services can begin without issues with overlapping services not allowed by DMAS.

3. Providers, if a member is on service with another provider that is prohibiting the service the member is requesting with you, the following option(s) are needed before requesting authorization:

a. The member calls the BH UM department to request discharge from service.
b. The provider calls with a member on the phone requesting discharge from the current service.
c. Provider that the services will be ending can send in a discharge notice.

Reinstatement of Authorization Requirments for ACT/MST/FFT

This is a reminder to all providers that provide ACT/MST and FFT services, that as of 1/1/2025 authorization will be required for these services for payment with Sentara. Please ensure you send in authorization requests to avoid claim denials, following the timely filing authorization request rules outlined by DMAS, as well as the required documentation for clinical review.

Improved Provider Portal Launch – 3rd Qtr., 2025

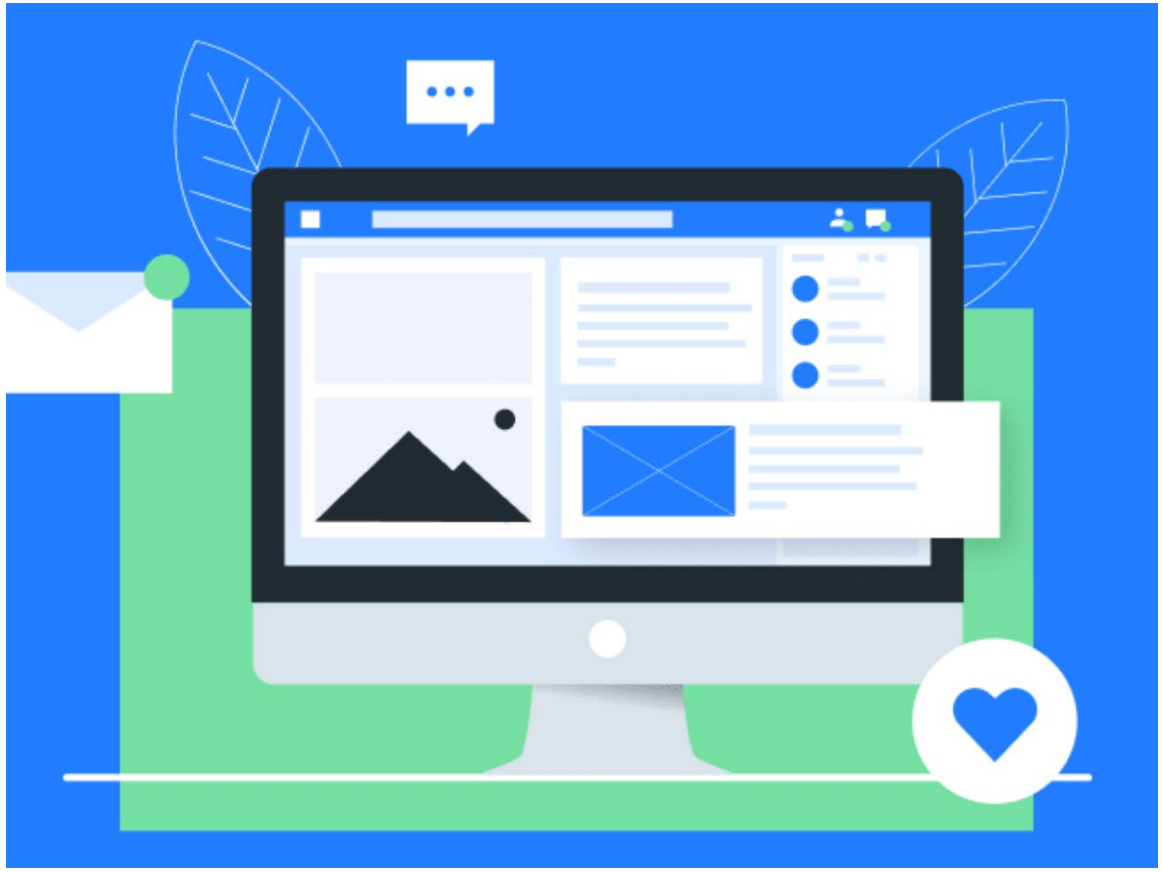
Processing faxed authorization requests requires significant manual work. This manual work leads to errors, delays in processing the requests, missing faxed requests, and the inability to do automated approvals.

We will begin educating and training providers on how to use the new provider portal in the second and third quarters of 2025. BH UM aims to receive 90% of all authorization requests via the new provider portal rather than via fax.

Could you help us reach that goal?

What that means to you is:

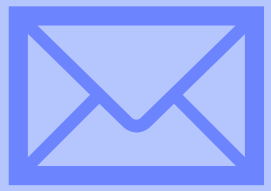
1. Faster turnaround times for your authorization requests.
2. Reduction in manual process work for providers submitting faxed service requests.
3. Automated approvals for services that do not need a clinical review and meet DMAS overlapping service requirements.
4. Ability to review the status/decision of request online versus calling Sentara Provider services.



Sentara Health Plans

Thank you for Partnering with Sentara Health Plans

Contact Us



CONTACTMYREP@sentara.com

4th Quarter Let's Talk Behavioral Health