Dear Provider,

This week, we are sharing the following provider updates — see below to learn more.

- Fair Business Practices Act – Electronic Communications Requirement
- Proper Corrected Claims Submission Reminder
- Revised Medicaid Provider Manual Now Available
- Legally Responsible Individuals (LRI) Nursing Delegation Frequently Asked Questions
- Update for Early Intervention Providers
- Important Reminder: Required Forms for Sterilization and Hysterectomy Procedures
- Medicaid Member Biologic Update
- Authorization Requirement for Yeztugo (lenacapavir)
- Upcoming Educational Opportunities

Fair Business Practices Act – Electronic Communications Requirement

The Fair Business Practices Act in Virginia establishes minimum fair business standards for health insurance carriers in the state. These standards include timely payment of claims, handling of additional documentation requests electronically, and specific guidance in provider contracts regarding required documentation for claims payment. As part of this act and required

by state law, **Sentara Health Plans is required to gather accurate contact information for our network providers to communicate electronically**.

Beginning January 1, 2026, Sentara Health Plans will notify providers of contractual and retroactive denial communications via email to comply with this requirement. This change will not impact current processes for Sentara Health Plans government programs.

Sentara Health Plans has established a form for you to easily update your information. **Please update as soon as possible!**

Proper Corrected Claims Submission Reminder

A corrected claim is a replacement of a previously submitted claim that requires changes or corrections to the charges, clinical or procedure codes, dates of service, or member information. A **claim** is being resubmitted by the provider to correct or change a previous submission *for the same patient, date of service, and/or procedures*. Please ensure that the appropriate claim lines reflect the original claims submission exactly. Claims should not be split when correcting the original claim. To learn more about submitting corrected claims on the UB-04 and CMS 1500, please review page 7 in **Overview of the Appeal, Reconsideration, and Contestment Processes,** located in our **Provider Toolkit.** You may also find the **Guide to Initial Submission of CMS 1500 and UB-04 Claim Forms** helpful, which is included in the toolkit.

Revised Medicaid Provider Manual Now Available

The annual review for the Sentara Health Plans Medicaid Provider Manual has been completed. This version reflects updates that align with regulatory and operational changes on topics such as:

- Adoption Assistance and Former Foster Care Enrollment
- Credentialing
- Primary Care Provider (PCP) Assignment
- Services Upon Identification of Pregnant or Postpartum Member
- Doula Qualifications and Doula Visit Requirements
- Interdisciplinary Care Team

- Residential Treatment Services
- Health and Preventive Services topics
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Treatment and Referrals
- Patient Pay for Long-Term Services and Supports (LTSS)
- Medication Therapy Management
- Clinical Practice Guidelines
- Claim Reconsiderations
- After-hours Availability and Appointment Timeliness Standards

Legally Responsible Individuals (LRI) Nursing Delegation Frequently Asked Questions

Who is an LRI?

- An LRI is a parent, stepparent, or guardian of a minor child, or a spouse primarily responsible for a member's daily care.
- LRIs may be reimbursed for personal care services for children under 18 with disabilities — only when the care exceeds what is typical for a child of the same age.
- LRIs can be paid for up to 40 hours per week per child, even if caring for multiple children.
- To be reimbursed, LRIs must meet the same qualifications as other personal care aides.
- Only Activities of Daily Living (ADLs) are reimbursable. Instrumental ADLs, supervision, and respite are not covered.

Why is identifying the LRI important?

- It ensures a clear point of contact for care coordination and delegated tasks.
- It supports continuity of care and accountability.

Examples of Delegated Caregiver Tasks

- Medication reminders or tracking
- Scheduling and attending appointments
- Reporting behavioral or health updates
- Assisting with home safety routines
- Supporting ADLs (e.g., bathing, dressing, eating)

Tasks That Cannot Be Delegated (Unless Exception Criteria Are Met)

(Note: Exception applies only if all delegation criteria are met per Department of Medical Assistance Services (DMAS) guidelines. Refer to pages 22–23 of the DMAS CCC Plus Waiver Manual.)

- Gastronomy tube feedings (NG, G-tube, J-tube)
- Foley catheter irrigations
- Sterile dressing changes
- Tracheostomy care
- IV therapies or injections
- Surgical wound care
- Any procedure requiring sterile technique

When May Skilled Tasks Be Delegated?

Per Virginia Code 18 VAC 90-20-420, skilled tasks may be delegated if all the following are documented:

- **RN Documentation:**
  - Name, license number, and qualifications
  - Assessment of the individual's clinical status and condition stability
  - Description of the specific tasks being delegated

- **Training and Competency:**
  - Evidence that the RN provided instruction to the aide/attendant
  - Confirmation that the RN witnessed the successful performance of the task by the aide/attendant

- **Ongoing Supervision:**
  - The RN must review and supervise the delegated activity at least every 90 calendar days (or more frequently if needed)

- **Physician's Order:**
  - A current physician's order for the service(s)

    - Orders must be updated every six months or sooner if the individual's condition changes

Helpful Resources:

- LRI Overview
- DMAS Memo
- LRI Forms:
    - Consumer-Direction Services Management Questionnaire
    - Community-Based Care Member Assess
- Extraordinary Care Chart

Update for Early Intervention Providers

Sentara Health Plans has successfully resolved the previous issue that made it difficult to reach provider customer service for in-person interpreter requests, including dropped calls and repeated attempts pressing “0.” To ensure a smooth process moving forward, a comprehensive job aid is now available, and instructor-led training sessions will be held January 13-15, 2026. These resources are designed to help providers confidently manage interpreter scheduling, rescheduling, and cancellations.

Links to join the training courses are as follows:

- January 13 – 9 a.m.
- January 13 – 12 p.m.
- January 14 – 9 a.m.
- January 14 – 12 p.m.
- January 15 – 9 a.m.
- January 15 – 12 p.m.

Important Reminder: Required Forms for Sterilization and Hysterectomy Procedures

This is a reminder to all providers that the following forms must be submitted with claims for specific procedures:

- DMAS 3004 Form – Required when sterilization is performed.

- DMAS 3005 Form – Required when hysterectomy is performed.

Failure to include these forms with your claims may result in the denial of claim payment.

Medicaid Member Biologic Update

Effective January 1, 2026, the adalimumab biosimilars noted below will be preferred over the branded reference product (Humira). On January 1, 2026, all members, including those currently stabilized on Humira, must be transitioned to one of the preferred biosimilars. Any current authorization in place for Humira will end on December 31, 2025, and will be transitioned to an authorization for the preferred biosimilar.

Drug Name	Status	New PDL Status	Notes
Adalimumab-adbm (unbranded Cyltezo manufactured by Boehringer Ingelheim)	Added	**Preferred**	Humira biosimilar - Max dose available 40mg. Multiple units needed for higher doses.
Adalimumab-bwwd (Hadlima)	Added	**Preferred**	Humira biosimilar - Max dose available 40mg. Multiple units needed for higher doses.
Humira	Status Change	**Non-Preferred**	Branded Reference Product
Pyzchiva syringe/vial	Added	**Preferred**	Stelara biosimilar. Requires trial and failure of one preferred TNF inhibitor)
Infliximab	Status Change	**Non-Preferred**	All infliximab products are now non-preferred. Requires trial and failure of two preferred agents. Additionally, all non-preferred infliximab products other than generic Remicade will require trial and failure of two preferred agents plus trial and failure of infliximab (generic Remicade) before any other infliximab product may be used.

Also, all members, including those currently stabilized on the reference product Stelara, must be transitioned to Pyzchiva. Any current authorization that is in place for Stelara will end on December 31, 2025, and be transitioned to an authorization for Pyzchiva syringe/vial.

The preferred biosimilar products are interchangeable with the branded reference product in alignment with the commitment to both optimal clinical outcomes and fiscally responsible healthcare.

Authorization Requirement for Yeztugo (lenacapavir)

Effective February 13, 2026, **J0738 – Yeztugo (lenacapavir)**, will require prior authorization for Sentara Medicaid. Providers must obtain authorization before administration and claim submission for J0738 to avoid claim denials.

Upcoming Educational Opportunities

New Provider Orientation

This webinar is for newly contracted providers, new hires, or anyone seeking a refresher on how to successfully conduct business with Sentara Health Plans. We will offer guidance on how to find solutions for common questions or challenges without contacting provider services.

To register, please visit sentarahealthplans.com.

Lunch & Learn: Provider Website Tour – Provider Orientation Part 2

Join us for an informal virtual session during the lunch hour. These sessions will be held twice monthly and are designed to help you learn how to navigate our provider website and explore our self-help resource library for guidance in successfully conducting business with us.

To register, please visit sentarahealthplans.com.

Sincerely,
Sentara Health Plans

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