Sentara Health Plans

Provider Alert

Urgent Provider News

March 29, 2024

Dear Provider,

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

- New Resources Available
- Scheduled Jiva Outage
- Sentara Health Plans Roundtable Meetings
- Three-Day Payment Window Policy
- Payment Policies in Availity
- New Paper Claims Vendor

New Resources Available

Please visit our **website** for new resources available to assist with closing care gaps.

- **Comprehensive Care Gap Guide for Medicare and Medicaid All Measures**
- **HEDIS Measure Issues and Actions for Compliancy**

Scheduled Jiva Outage

To perform the required work to upgrade to Jiva 6.6, an outage is scheduled for Friday, March 29 at 5:30 p.m. Registered Provider Connection users will sign in and begin using the new Jiva 6.6 to submit and track authorizations on Monday, April 1.

Sentara Health Plans Roundtable Meetings

Sentara Health Plans actively seeks opportunities to support our provider partners so you can conduct business with us successfully. We are offering roundtable meetings in April. The purpose is to provide an informal setting to discuss integration related issues and concerns regarding claims and provider portal usage. Provider surveys are listed below to gather your

feedback which will assist our team in preparing for the event. The meetings will have a limited number of attendees so please register early. Our first meeting is scheduled for April 9 from 7-8 a.m., we will be discussing the provider portals.

- **Access the provider portal survey**
- **Access the claims survey**

Register for upcoming roundtable meetings:

- Provider Portals - April 9, 7-8 a.m.
- Claims Roundtable - April 17, 1-2 p.m.
- Claims Roundtable - April 23, 7-8 a.m.

Three-Day Payment Window Policy

Effective June 1, Sentara Health Plans will implement a requirement of a three-day payment window, in accordance with the Centers for Medicare & Medicaid Services (CMS) regulations.

Sentara Health Plans adheres to the "3-day (or 1-day) payment window" policy. We follow the CMS definitions when determining reimbursement for outpatient diagnostic and nondiagnostic services preceding an inpatient admission. If an admitting hospital furnishes diagnostic services three days prior, including the date of a patient's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (e.g. bundled service). If a hospital renders nondiagnostic outpatient services three days prior, including the date of a patient's inpatient admission, and the nondiagnostic outpatient services are related to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

A service is diagnostic if it is an examination or procedure to which the patient is subjected, or which is performed, on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury." (Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1).

A service is nondiagnostic if it is not identified by a diagnostic service revenue code or CPT code. (American Medical Association, Current Procedural Terminology Manual).

Effective June 1, Sentara Health Plans will begin applying claim edits to enforce this policy. This requirement will be applicable across all commercial, Medicaid, and Medicare products. Please review payment policy 3934:Three-Day Payment Window. (Provider Connection sign in credentials will be required. Unregistered providers click **here**.)

Payment Policies in Availity

You may now access our payment policies through the **Availity** Payer Space under the resource tab.

New Paper Claims Vendor

Beginning on July 1, Sentara Health Plans will transition our paper claims processing functions to FirstSource, a third-party vendor responsible for the intake and processing of mailed claims. To help support this transition, we are reaching out to our provider community ahead of the go-live to communicate the change and ensure our provider partners have the details needed to submit claims successfully.

As part of this transition, submitted paper claims will be processed according to billing requirements consistent with CMS and Department of Medical Assistance Services (DMAS). This change will ensure health plan compliance, ensuring our received paper claims include the required fields and formatting to process as clean claims. Providers who previously submitted paper claims to Sentara Health Plans could see a change in processing. With the change to this vendor, claims that were previously processed by Sentara Health Plans and denied for missing information will be rejected prior to health plan processing. This will result in faster exchange of information to allow for an opportunity for re-billing or correcting claims.

We also always encourage providers to submit claims electronically for the quickest and most effective processing route. As an additional option, providers can use the provider portal through Availity to submit single claims electronically. More information can be found here.

Sincerely,
Your Sentara Health Plans Team