Dear Provider,

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

- Authorization Updates Effective August 1
- Policy Updates Effective August 1
- Pharmacy Update

Authorization Updates Effective August 1

Sentara Health Plans has a new medical policy weblink available to access all current behavioral health, durable medical equipment, imaging, medical, obstetrics, pharmacy, and surgical policies. You can access this at sentarahealthplans.com/providers/clinical-reference/medical-policies.

Visit our website to view the most recent authorization updates.

Policy Updates Effective August 1

Sentara Health Plans follows the Centers for Medicare & Medicaid Services (CMS) guidance for:

Anatomical Modifiers

According to the CMS Claims Processing Manual, “when certain component codes or mutually exclusive codes are appropriately furnished, such as later on the same day or

on a different digit or limb, it is appropriate that these services be reported using an healthcare common procedure coding system (HCPCS) code modifier."

Enforcement of correct coding guidelines, regarding anatomical modifiers, is an important aspect of payment integrity code editing. Without the proper anatomical modifier applied to the procedure code, there is a risk of duplicate claims payment, incorrect procedure-to-procedure bundling, incorrect frequency limitations, and unnecessary medical record review. So therefore, Sentara Health Plans will be deploying an edit that reviews surgical procedures on the foot and toes (code range 28001-28899*) and the hand and fingers (code range 26010-26989*) when they are not reported with the appropriate anatomical modifier.

Note: Included codes must represent a digit.

Institutional Billing for No Cost Items

The Medicare Claims Processing Manual Chapter 32 - Billing Requirements for Special Services section 67.2 outlines institutional billing for no cost items as follows:

Institutional providers should not have to report on the usage of a no cost item. However, claims providers may be required to bill a no cost item due to claims processing edits that require an item (even if received at no cost) to be billed along with an associated service.

For example, when a drug is provided at no cost, claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. Therefore, for drugs provided at no cost in the hospital outpatient department, providers must report the applicable drug HCPCS code and appropriate units with a token charge of less than $1.01 for the item in the covered charge field and mirror this less than $1.01 amount reported in the non-covered charge field.

Providers must also bill the corresponding drug administration charge with the appropriate drug administration current procedural terminology (CPT) code or HCPCS code.

Pharmacy Update

Effective August 1, 2025, Sentara Health Plans will require prior authorization for HCPCS codes J9297, J9294, J9296, J9323, and J9322 for Medicare, Medicaid, and commercial plans.

Sincerely,
Sentara Health Plans

Register for upcoming provider webinars
View current policy and operations changes