Sentara® Health Plans

Provider Newsletter

Fall 2024

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Sentara®
Health Plans

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Ensure Our Members Know You Participate in the Sentara Health Plans Network

Please update your accepted insurance lists and all informational materials to reflect our new name, Sentara Health Plans. It is also important to ensure that front office and patient-facing staff members are informed as they may receive inquiries regarding coverage. This is an easy way to ensure our members maintain uninterrupted and timely access to necessary healthcare services.

Iris by OncoHealth

In partnership with Sentara Health Plans, Iris by OncoHealth provides 24/7 oncology-specific support for individuals with cancer and their caregivers. This virtual care service complements existing oncology team care by providing personalized ongoing support between appointments and after-hours.

Iris connects members with licensed oncology experts—including mental health therapists, dietitians, and nurses—who offer personalized care for managing all aspects of their cancer experience. Members also have access to local and national supportive resources and an extensive content library.

Accessible via web, smartphone app, or phone and available at no cost to eligible members Iris provides direct access to oncology-certified providers, helping to improve well-being for those facing cancer. To learn more about Iris by OncoHealth, **click here**.

Avalon Services Expand to Genetic Testing Management

Sentara Health Plans will continue its collaboration with **Avalon Healthcare Solutions** (Avalon) to implement the **Genetic Testing Management (GTM)** services program starting with select commercial plans beginning on December 1*. More details will follow in the next few weeks.

Please note that we plan to implement this program for our Medicaid members during the first quarter of 2025.

The Avalon program emphasizes peer-to-peer education to promote appropriate testing and reduce potential for service denials. Preservice Authorization System (PAS) is used to apply Sentara Health Plans' policies, codes that require preservice review, and provide self-service access to request authorizations.

The GTM program includes important changes, such as new and revised medical policies supported by Avalon's experts in lab and genetic testing, a new authorization request process, guidelines, and consistent preservice reviews for certain genetic testing services that will be applicable to both ordering and rendering provider partners.

Additional details are forthcoming, but until then please note:

- Effective December 1, providers will need to submit requests for authorization for specific genetic tests for select commercial plans using PAS.
- Authorizations previously issued before the implementation date will be effective until the expiration date.
- New authorization requests must be submitted for select commercial plans to Avalon on or after December 1 dates of service.
- Avalon adds clinical and quality components, which will be outlined during our training sessions designed for your clinical and administrative decision makers. The training dates will be announced soon.

** Implementation will be based on individual program contract renewal dates. More information to come regarding specific go-live dates by product.*

Access to Care - Sentara Health Plans Appointment 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, seven-day per week basis, following 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.

Appointment access standards for commercial (HMO/POS/PPO) plans:

Service	**Sentara Health Plans Commercial Standards**
Emergency appointments, including crisis services	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request.
Urgent appointments	Within 24 hours of the member's request
Routine primary care	Must be made within 14 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations; for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently; or for routine specialty services like dermatology, allergy care, etc.
Maternity care – first trimester	Within 7 calendar days of request
Maternity care – second trimester	Within 7 calendar days of request
Maternity care – third trimester	Within 3 business days of requests
Maternity care – high-risk pregnancy	Must be made within 3 days of high-risk identification, or immediately if an emergency exists
Postpartum	Within 60 days of delivery
Preventive care	Within 60 days of member's request
Routine behavioral health/substance use disorder initial visit	Within 10 business days
Routine behavioral health/substance use disorder follow-up visit	Within 14 calendar days

Service	Sentara Health Plans Commercial Standards
After-hours care	As a condition of participation, providers must provide covered services to members on a 24-hour per day, 7-day per week basis

Appointment access standards for Medicare plans:

Service	Sentara Health Plans Commercial Standards
Urgently needed services or emergency	Immediately
Services that are not emergency or urgently needed, but the member requires medical attention	Within 7 business days
Routine and preventive care	Within 30 business days

Appointment access standards for the Medicaid program:

Service	Sentara Health Plans Commercial Standards
Emergency appointments, including crisis services	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request. Follow up to crisis services must be made within 24 hours of Sentara Health Plans being notified of the crisis services utilization.
Urgent appointments	Within 24 hours of the member's request
Routine primary care services	Routine, primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.
Maternity care – first trimester	Within 7 calendar days of request
Maternity care – second trimester	Within 7 calendar days of request
Maternity care – third trimester	Within 3 business days of requests
Maternity care – high-risk pregnancy	Within 3 business days of high-risk identification to Sentara Health Plans or a maternity provider, or immediately if an emergency exists
Postpartum	Within 60 days of delivery
Mental health services	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met
LTSS	As expeditiously as the member's condition requires and within no more than 5 business days from Sentara Health Plans' determination that coverage criteria are met

Case Management Awareness : Help Your Patients Achieve Their Health Goals

At Sentara Health Plans, our case management team is available to support members in managing their health. Our team of registered nurses, health coaches, and social workers work with you to empower members with personalized guidance and support.

What Can Case Management Do?

- Tailor health solutions and answers to specific health needs
- Support and education for chronic condition management
- Develop individualized care plans with measurable goals
- Advocacy to overcome barriers to care
- Coordinate healthcare services

When to Connect with Case Management?

Members should reach out to Sentara Health Plans' Case Management team if they:

- Need help understanding a diagnosis, medication, or treatment plan
- Were recently discharged from the hospital or emergency department
- Need assistance obtaining equipment or achieving a health goal

How to Connect?

Encourage Sentara Health Plan members to take the first step by calling our case management team at **1-866-503-2730**. For general inquiries about authorizations, payments, or provider networks, members can contact member services by calling the number on their ID card or they can access information by visiting **sentarahealthplans.com/members**.

We believe that by working together, we can make a meaningful difference in the health outcomes of patients and members.

Welcoming Baby Program

Welcoming Baby is Sentara Community Plan's incentive-based prenatal and postpartum care program for our members. It includes:

- Pregnant members from conception
- Birth
- Postpartum care for up to 12 months
- Watch Me Grow child outreach to babies from birth to 15 months

What do your patients receive from this program?

- One-on-one supportive services from a certified community health worker (outreach representative) and a maternity case manager and/or behavioral health maternity care coordinator
- Screening and referral to maternity case manager/care coordinators for care planning and goal setting
- Management of high-risk conditions
- Education, community referrals for identified needs
- Family planning, long-acting reversible contraception (LARC), and birth spacing education
- Virtual and in-person baby showers
- Access to breast pumps
- Maternal/child education series classes (virtual)
- Referrals to parenting, breastfeeding classes, and lactation services
- Virtual and in-person hospital tours
- Timeliness of care incentives

Contact the Welcoming Baby outreach team

Phone: 1-844-671-2108 (TTY: 711)
Monday through Friday 8 a.m.–5 p.m.

Email: welcomingbaby@sentara.com

Timeliness of Prenatal and Postpartum Care

Our members are encouraged to seek timely and consistent prenatal and postpartum care with their providers. Members receive reminders, education, and incentives through the Welcoming Baby Program if they have their first prenatal visit within 42 days of enrolling with Sentara Community Plan or within their first trimester. Members will receive the same benefits if they have a timely postpartum provider visit within 7-84 days of giving birth.

OB Registration Program: Early Identification of Pregnancy

- Providers are eligible to receive a $25 incentive for referring pregnant patients to Sentara Health Plans' Welcoming Baby Program upon identification of pregnancy for Medicaid members.
- Providers must complete the **Welcoming Baby OB Registration Form**, fax it to Outreach at **804-799-5117**, and submit a claim using the code G9001.
- Providers can also email the form to **welcomingbaby@sentara.com**.

Health Equity Index Reward

The Centers for Medicare & Medicaid Services (CMS) Final Rule, published in the Spring of 2023, finalized the Health Equity Index Reward to incentivize Medicare Advantage and Part D plans to focus on improving care for members with Social Risk Factors.

In 2024 and 2025, CMS is focusing on patients who receive Low-Income Subsidy (LIS) or "Extra Help," those who are dually eligible for Medicare and Medicaid, and Medicare members with disability status. These circumstances are considered social risk factors that create barriers to positive health outcomes.

CMS recognizes the disparities created by poverty, discrimination, and lack of access and plans to reward Medicare plans that excel at creating equitable outcomes for their members*.

Patient Focus in 2024 and 2025:

- Low-income subsidy or "Extra Help"
- Dual Eligibility (DE) [Eligible for both Medicare and Medicaid]
- Disability status

Barriers to positive health outcomes for LIS/DE and Disabled Patients:

- Limited education
- Low income
- English as a Second Language (ESL) or no English
- Food insecurity
- Lack of social support
- Lack of digital access
- Lack of transportation
- Functional limitations
- Cognitive impairments or needs
- Poor health
- Behavioral health needs

Sentara Medicare Member Services can be reached at **1-800-927-6048 (TTY: 711)**.

In 2022, these patients had significantly lower rates for:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Diabetes – Eye Exam
- Diabetes – Blood Sugar Controlled
- Controlling Blood Pressure

Working together to create equitable outcomes by addressing social determinants of health (SDOH) and providing holistic care:

Sentara Medicare offers a range of extra benefits and programs to qualifying members to address some of these common barriers:

- Grocery benefit
- Over-the-counter product allowance
- Transportation (medical and non-medical)
- Post-discharge meals delivered
- In-home/companion support
- Care coordination
- Special programs for patients with chronic conditions such as diabetes and hypertension
- Health risk assessment to identify needs

Healthcare Providers can help by:

- Assessing for SDOH
- Flagging at-risk patients
- Spending 2-3 extra minutes to address complexity
- Maintaining a community resource guide
- Using plain language alternatives to medical jargon
- Using Z-codes to track and analyze SDOH trends
- Encouraging patients to engage with their health plan's supplemental benefits and special programs
- Encouraging patients to apply for "Extra Help", the Medicare program that pays Part D premiums, deductibles, coinsurance, and other costs

**CMS Framework for Health Equity 2022-2032*

Changes to Sentara Health Plans Network Structure

Sentara Health Plans will no longer offer Direct network plans starting on January 1, 2025, to Individual & Family Health Plans and Small Group members. Our Direct network was structured into two tiers, providing different levels of member cost-sharing responsibility. In the 2025 plan year, all plans will be offered in our standard one-tiered network. Members will enjoy full access to our existing broad network of doctors and facilities, with no difference in cost-sharing between tiers.

The Sentara Direct® network was structured as follows for certain services:

- Tier 1: All Sentara Health Plans participating providers except those listed in Tier 2
- Tier 2: Mary Washington Healthcare doctors and facilities

In the 2025 plan year, all Sentara Health Plans providers, including Mary Washington Healthcare, will be considered Tier 1 providers.

How will this change impact members?

Members with Direct plans will be automatically mapped to an equivalent plan, Direct will no longer be included in our plan names. This change will be reflected on new member ID cards.

Dedicated D-SNP Member Services Phone Number

Sentara Health Plans now has a dedicated phone number, **1-866-650-1274 (TTY: 711)**, for the Sentara Community Complete (HMO D-SNP) plan. Please encourage Sentara Health Plans Community Complete members to use this dedicated line beginning January 1, 2025.

D-SNP Member Services is available October 1 through March 31, 7 days a week, from 8 a.m. to 8 p.m., or April 1 through September 30, Monday through Friday, from 8 a.m. to 8 p.m.

For all other Medicare plans, please call **1-800-927-6048 (TTY: 711)** to contact member services.

Quest Diagnostics to become the National Lab Provider for Sentara Health Plans

Beginning on January 1, 2025, Quest Diagnostics will be the exclusive independent national laboratory provider of clinical laboratory and anatomic pathology services for members of Sentara Health Plans commercial and government programs.

The agreement will apply to Sentara Health Plans members in Florida and Virginia, including those in Sentara's Florida-serving AvMed business.

Quest is one of the world's leading providers of diagnostic testing information services and is committed to delivering the best possible laboratory services to our members. They currently have over 40 patient service centers and draw site locations within Virginia. Quest also has a daily courier service which picks up specimens from all medical offices and facilities in your plan's provider network throughout the entire state.

Quest and Sentara Reference Labs (SRL)

The table below outlines the members – commercial (employer group and Individual & Family plans), Medicaid, and Medicare – who will be served by Quest and/or Sentara Reference Labs (SRL):

Membership	Quest	Sentara Reference Labs (SRL)
Commercial (in Hampton Roads)	In-network **for certain self-funded groups only.**	In-network for all employer group plans and Individual & Family plans.
Commercial (outside Hampton Roads)	In-network for all employer group plans and Individual & Family plans.	In-network for all employer group plans and Individual & Family plans.
Medicaid (in Hampton Roads)	Not in-network, see SRL.	All lab services and specimen collection.
Medicaid (outside Hampton Roads)	All lab services.	Available for specimen collection only (must be sent to Quest).
Medicare (in Hampton Roads)	Not in-network, see SRL.	In-network for Medicare Advantage and D-SNP.
Medicare (outside Hampton Roads)	In-network for Medicare Advantage and D-SNP.	In-network for Medicare Advantage and D-SNP.

For our Sentara Medicaid members, Quest will be providing all lab services for members residing outside of Hampton Roads. While all Sentara patient service centers and draw site locations will be available for specimen collection, all specimens in this area need to be sent to Quest for processing.

Medicaid members residing within the Hampton Roads service area will continue to use Sentara Reference Labs for all lab services.

Quest will also be a network option for all employer group plans, individual and family plans, Medicare Advantage and D-SNP (Dual Eligible Special Needs Plans) products outside of Hampton Roads and for select self-funded groups within Hampton Roads.

Sentara Reference Labs will remain in-network for all employer group plans, individual and family plans, Medicare Advantage and D-SNP products statewide.

For your reference, the following cities/counties comprise the Hampton Roads area:

- Accomack
- Chesapeake
- Gloucester
- Hampton
- Isle of Wight
- James City County
- Mathews
- Newport News
- Norfolk
- Northampton
- Poquoson
- Portsmouth
- Southampton
- Suffolk
- Surry
- Sussex
- Virginia Beach
- Williamsburg
- York

Please be aware that LabCorp will no longer provide services to Sentara Health Plans members effective January 1, 2025. Their patient service centers will not be in-network to utilize as draw sites. In addition, providers collecting specimens within their office or facility will no longer send these to LabCorp for testing.

To schedule specimen pickups or a daily courier service with Quest, please call **1-866-MYQUEST** or go to: **QuanumLSM.com**.

Sentara Health Plans, Sentara Reference Labs, and Quest Diagnostics all share a common goal to deliver quality and affordable care to our plan members.

Sentara Employees Living in Virginia Will Now Be Covered by Sentara Health Plans

Beginning January 1, 2025, Sentara employees living in Virginia will be covered by Sentara Health Plans instead of Cigna. The Sentara Health Plans provider network has expanded, and we are welcoming new members.

Please be on the lookout for our members as they call or visit your office. Be sure to request their Sentara Health Plans member ID card to confirm their new plan and costs for services.

Eligibility and Benefits Are Now Live in Availity Essentials

You can now submit eligibility and benefits inquiries in Availity Essentials to Sentara Health Plans. This is part of a phased migration of transactions and more features will be released soon to streamline your workflow.

Stay up-to-date on the availability of features **here**.

Early Intervention (EI) Providers

Attention Early Intervention (EI) Providers:
To ensure timely receipt and processing Individualized Family Servicer Plan (IFSP) forms must be submitted by fax to **757-390-4449**, **1-833-459-0774**, or emailed to **highriskpeds@sentara.com**.

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DMAS Updates

- 23-Hour Crisis Stabilization Services – Regulatory Update

23-Hour Crisis Stabilization Services – Regulatory Update

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is requiring providers of 23-hour Crisis Stabilization services to obtain one of the following licenses:

- MH Center-Based Crisis Receiving Center for Adults (02-040) and/or
- MH Center-Based Crisis Receiving Center Children and Adolescents (02-041)

Current providers of 23-Hour Crisis Stabilization services have 90 days from July 17, 2024 to obtain the appropriate license for the service being provided and must complete the Department of Medical Assistance Services (DMAS) enrollment process with the new license. Providers of 23-Hour Crisis Stabilization are required to do all the following actions by October 17, 2024.

If you are a Sentara Health Plans participating provider who offers 23-Hour Crisis Services and do not meet the October 17 deadline of enrolling with the new DBHDS license and applicable provider type(s) and specialty, you will not be eligible to provide these services for Sentara Health Plans or be reimbursed by DMAS or its contractors until enrollment is complete and approved. Please be advised that any requests for retroactive claims reimbursements for 23-Hour Crisis Stabilization services for any provider not in possession of the updated licensure(s) by October 17 will be denied by Sentara Health Plans and will not be paid under any circumstances—no exceptions.

Participating providers will also receive a detailed letter about this regulatory change via USPS mail.

Please send a copy of your new license to our credentialing department via email at **Cred_Org_Apps@sentara.com** and in the subject line please note: New 23-Hour Crisis Stabilization License.

We appreciate your assistance in serving our members and meeting their healthcare needs.

Sentara® Health Plans

Quality Improvement

- Dr. Melvin T. Pinn, Jr. Quality Excellence Award Recipient: Dr. Walker A. Julliard
- CAHPS Measures
- Finding Plan Information
- Encourage Members to Get Well-Child Visits
- Clinical Practice Guidelines
- Quality Management Review Tips for Adult Day Health Care Centers (ADHC)

Dr. Melvin T. Pinn, Jr. Quality Excellence Award 2024 Recipient:

Dr. Walker A. Julliard

Sentara Health Plans' quality member safety team is excited to announce the 2024 **Dr. Melvin T. Pinn, Jr. Quality Excellence Award (QEA) Award recipient—Dr. Walker A. Julliard**! Dr. Julliard underwent a thorough review, met the requirements, and was selected to receive this prestigious award by the QEA committee's consensus vote.

Dr. Julliard is a cardiothoracic surgeon, with specific expertise in the surgical treatment of non-cardiac diseases of the chest, including lung cancer and malignant pleural mesothelioma. He is affiliated with Virginia Commonwealth University Health System and Massey Comprehensive Cancer Center. Dr. Julliard is particularly skilled in minimally invasive surgical procedures including thoracoscopic, robotic, and laparoscopic methods as well as traditional open techniques and endoscopic non-surgical approaches.

He has received high ratings from his patients and patients' loved ones. He was nominated to receive the Dr. Melvin T. Pinn, Jr. Quality Excellence Award with an excerpt of a written testimony stating, "Our family is so thankful for Dr. Julliard and how his attention to detail gave us all the best outcome."

In his personal life, Dr. Julliard enjoys spending time outdoors hiking and backpacking with family.

The Dr. Melvin T. Pinn, Jr. QEA is a prestigious recognition program designed to recognize physicians for demonstrating commitment to quality care and safety while improving outcomes for members. Throughout the calendar year, nominations are accepted, and one physician is selected annually to receive this accolade for the delivery of safe clinical practices and quality care.

The quality member safety team is accepting nominations for the 2025 QEA Award. **Please click this link to submit your nomination.**

CAHPS Measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measure: Getting Needed Care

The **Getting Needed Care** measure assesses the ease with which patients receive necessary care, tests, or treatment. It also assesses if the patient was able to get an appointment with a specialist as soon as needed.

Tips to incorporate in your daily practice:

- Have office staff coordinate patient appointments with specialists.
- Encourage patients and caregivers to view results on the patient portal when available.
- Encourage patients to pre-schedule their next appointment.
- Remind patients 48 hours before their appointment to reduce no-shows.
- Inform patients of what to do if care is needed after hours such as visiting their nearest urgent care center or utilizing telehealth platforms.
- Offer appointments or refills via text and/or email.

CAHPS Measure: Getting Appointments and Care Quickly

The **Getting Appointments and Care Quickly** measure assesses the member's perception of how quickly they received needed care and how often appointment wait times exceeded 15 minutes.

Tips to incorporate in your daily practice:

- Remind patients 48 hours before their appointment to reduce no-shows.
- Remind patients of available care options i.e. telehealth.
- Ensure there are appointments available each day to accommodate urgent visits.
- Offer appointments with a nurse practitioner or physician assistant for short notice appointments.
- Keep patients informed by text, phone, or in the waiting room if there are wait time delays to help manage patient expectations. Give members an option to reschedule, if needed.
- Maintain a triage system to ensure that very sick patients are seen right away.

Finding Plan Information

As a valued provider in our network, we want you to know where to find the information about our plans' coverage. Important details can be found at **sentarahealthplans.com** on the 'Member' page of the Medicaid member handbook, member guide, and in the Evidence of Coverage/Certificate of Insurance for commercial and Virginia's Insurance Marketplace members.

Please click here to view the resources available with our plans.

Encourage Members to Get Well-Child Visits

ATTENTION: Time is running out! The third quarter of 2024 is coming to an end!

Sentara Health Plans offers a $25 gift card to Marketplace members for completing their annual Well Child Visit. Members 3 to 21 years of age are eligible for this incentive.

Help our members score the winning touchdown in the fourth quarter of the year by encouraging them to complete a Well Child Visit by December 31, 2024.

How can you help? See some simple tips below:

- Inform parents/members of the importance of well-child visits.
- Send appointment reminders. Ensure parents are signed up to receive reminders.
- Allow scheduling the next annual checkup at this year's checkup.
- Offer well-care appointments outside of standard business hours.
- Keep in mind that parents may be attempting to schedule appointments on their work break. Monitor the hold time needed to reach a scheduler.
- Monitor clinic wait times to ensure members are being seen in a timely manner.
- Mention to members that managed care organizations offer incentives to the member or parent.

Click this link to access the Well Child Visit Reward landing page.

Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are adopted to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. Sentara Health Plans adopts and disseminates CPGs relevant to its membership for the provision of health, acute, and chronic medical services, and for preventive and non-preventive behavioral health services.

All clinical or preventive health practice guidelines that are adopted or developed are:

- Based on valid and reliable clinical evidence-based practices or a consensus of healthcare professionals in the respective field
- Considerate of the needs of the members
- Reviewed and updated, at minimum, every two years, as applicable
- Disseminated to practitioners and members annually
- Provided a basis for utilization decisions, member education, and service coverage

Sentara Health Plans ensures network providers utilize appropriate evidence-based clinical practice guidelines through web technology, the use of electronic databases, and manual medical record reviews, as applicable, to evaluate the appropriateness of care and documentation. A modified approach to the utilization of clinical practice guidelines and nationally recognized protocols may need to be taken to fit the unique needs of all beneficiaries.

These medical and behavioral health guidelines are based on published national guidelines, literature reviews, and the expert consensus of clinical practitioners. They reflect current recommendations for screening, diagnostic testing, and treatment. These guidelines are published by Sentara Health Plans as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these guidelines. The Sentara Health Plans guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment. Copies of clinical guidelines are available via mail, email, or fax. To request a printed copy of the health plan's CPGs, please contact the member safety department at **757-252-8400** or toll-free at **1-844-620-1015**. CPGs are also available on **sentarahealthplans.com**.

Quality Management Review Tips for Adult Day Health Care Centers (ADHC)

The Quality Management Review (QMR) is the process by which DMAS and/or Sentara Health Plans assess and evaluate waiver services and their providers. The purpose of the QMR is to ensure the provider's overall compliance with the administration of home and community-based waiver services in the Commonwealth of Virginia. QMRs are not to be confused with utilization reviews and are not a financial audit. The QMR process includes a review of waiver services along with ensuring those services are being provided in accordance with DMAS regulations, policies, and procedures as outlined in the Commonwealth Coordinated Care Plus (CCC+) Waiver Provider Manual. The goal of the QMR is to ensure the health, safety, and welfare of the individuals receiving waiver services. Areas of review include, but are not limited to provider qualifications, individual eligibility criteria, individualized personal needs, quality of care, and adequate record keeping.

For ADHC providers, some of the most common compliance issues are as follows:

- **Failing to identify an ADHC coordinator in the member's file.** All members should have a specific person in charge to coordinate concerns while in the ADHC facility and between the member and other participants in the member's care. It might seem logical to assume that this person is the program director, and even though neither the DMAS 301 nor 302 forms ask specifically for this information, it should be well documented in the member's file to meet the requirement DMAS specifies in the CCC+ Waiver Provider Manual, chapter 2, page 26 of the 12/27/23 revision.
- **Failing to have a plan in place in case the member requires an unexpected ride home.** A backup transportation method should be documented in the member's file to help meet the DMAS requirement mentioned in the CCC+ Waiver Provider Manual, chapter four, page 47 of the 12/29/2023 revision.
- **Failing to develop goals that are member-centric.** It is very important to complete the DMAS 301 form with member goals in mind. You can use the form for up to three updates of the quarterly Interdisciplinary Care Team meeting. Team members should initial the entries/updates and clearly identify themselves on the form. This will help meet the DMAS requirement mentioned in chapter four, page 50.
- **Failing to write an individualized monthly review, complete a functional assessment, make note of the member's current medical condition and any recent updates to the member's condition or support system,** whether any of the other caregivers are covered under the CCC+ Waiver or other sources. Member medications and any known allergies must be updated regularly, regardless of whether the member is administered medication at the center. This will help meet the requirement DMAS specified in chapter four, page 52.
- **Failing to complete the DMAS 302 form weekly.** The center must document the member's arrival and departure times, the total time in the center, and tasks that the center provided that day. Additionally, at least one significant comment (more if needed) should be included about the member's time in the center that week, before having the appropriate person sign and date the document at the end of the week. For all comments made earlier in the week, comments should be signed and dated by the person writing the comment. This will help meet DMAS requirements found in chapter four, page 51.
- **Failing to keep in mind that repetitive documentation or preprinted comments or forms do not meet DMAS requirements.** Documentation should tell the story of the member. Consistently documenting "No concerns noted or reported," or "No changes observed or reported," does not meet compliance. This is specified in chapter six, pages 11-12 of the 5/16/24 revision.

For the most recent DMAS CCC+ Waiver Provider Manuals, please access them **here**.

Sentara® Health Plans

Authorizations, Medical Policies, and Billing

- Authorization Updates, Effective September 1, 2024
- New Fourth Quarter CPT/HCPCS Codes, Effective October 1, 2024
- Authorization Requirements Updates (Medicare/Medicaid)
- Updates to G2211 for Commercial Lines of Business
- Commercial Fully Funded Plans Prior Authorization Updates, Effective January 1, 2025

Authorization Updates, Effective September 1, 2024

Visit our website to view the most recent authorization updates. Access all current behavioral health, durable medical equipment, imaging, medical, obstetrics, pharmacy, and surgical policies at **sentarahealthplans.com/providers/clinical-reference/medical-policies**.

New Fourth Quarter CPT/HCPCS Codes, Effective October 1, 2024

104 new CPT and HCPCS codes became effective October 1, 2024, for drugs, professional services and procedures, supplies, durable medical equipment, and quality measures. Coverage determination and authorization requirements for Medicare and Medicaid are available via the Prior Authorization List on the Sentara Health Plans website.

- 58 new HCPCS codes.

  Note:

  - New code J0175 is effective July 2, 2024
  - New codes Q0519, and Q0520 are effective September 15, 2024
  - All other codes are effective October 1, 2024
- 46 new CPT codes
  - All codes are effective October 1, 2024
- 11 codes were termed effective October 1, 2024

Code changes and deleted codes are uploaded to **sentarahealthplans.com**.

Authorization Requirements Updates (Medicare/Medicaid)

Authorization requirements were updated for the attached codes:

- 14 codes prior authorizations were updated to reflect 'No Auth Required' for Medicaid
- 10 codes prior authorizations were updated to reflect 'No Auth Required' for Medicare
- 5 codes prior authorizations were updated to reflect 'Auth Required' for Medicare
- 1 code prior authorization was updated to reflect 'Auth Required' for Medicaid

PROCEDURE CODE	DESCRIPTION	SENTARA HEALTH PLANS MEDICAID AUTH REQUIRED	SENTARA HEALTH PLANS MEDICAID EFFECT DATE
49320	LAPS ABD PRTM&OMENTUM DX W/WO SPEC BR/WA SPX	NO	October 1, 2024
99473	SELF-MEAS BP PT EDUCAJ/TRAIN	NO	October 1, 2024
99474	SELF-MEAS BP 2 READG BID 30D	NO	October 1, 2024
90870	ELECTROCONVULSIVE THERAPY	NO	July 1, 2024
96116	NUBHVL STATUS XM PR HR W/PT INTERP&PREP	NO	July 1, 2024
E8000	POSTERIOR GAIT TRAINER PEDIATRIC SIZE	NO	October 1, 2024
E8001	UPRIGHT GAIT TRAINER PEDIATRIC SIZE	NO	October 1, 2024
E8002	ANTERIOR GAIT TRAINER PEDIATRIC SIZE	NO	October 1, 2024
99374	PHYS SUPVJ PT HOME HLTH AGENCY MO 15-29 MINUTES	NO	January 1, 2024
99375	PHYS SUPVJ PT HOME HLTH AGENCY MO 30 MIN/>	NO	January 1, 2024
99377	PHYS SUPVJ HOSPICE PT MO 15-29 MIN	NO	January 1, 2024
99378	PHYS SUPVJ HOSPICE PT MO 30 MIN/>	NO	January 1, 2024
99379	PHYS SUPVJ NF PT MO 15-29 MIN	NO	January 1, 2024
99380	PHYS SUPVJ NF PT MO 30 MIN/>	NO	January 1, 2024

Code changes and deleted codes are uploaded to **sentarahealthplans.com**.

Updates to G2211 for Commercial Lines of Business

Authorization requirements for G2211 have been updated to reflect 'Not Covered' effective January 1, 2024.

PROCEDURE CODE	DESCRIPTION
G2211	COMPLEX E/M VISIT ADD ON

Evaluation and Management Payment Policy 3838 has been updated to reflect 'Not Covered' for commercial lines of business as G2211 is bundled into the evaluation and management code and is not separately reimbursable.

Commercial Fully Funded Plans Prior Authorization Updates, Effective January 1, 2025

Visit our website to view authorization requirements for 1,026 procedure codes will be updated effective January 1, 2025, for commercial fully funded lines of business.

Sentara® Health Plans

Pharmacy

- Pharmacy Formulary Updates

Pharmacy Formulary Updates

The Sentara Health Plans Pharmacy and Therapeutics Committee (P&T) meets at least bimonthly to provide strategic clinical direction on formulary management and clinical programs. Clinical recommendations made by the committee may result in drug formulary placement updates. These updates help ensure that the most clinically appropriate, cost-effective formulary drugs remain accessible and that contractual obligations are maintained.

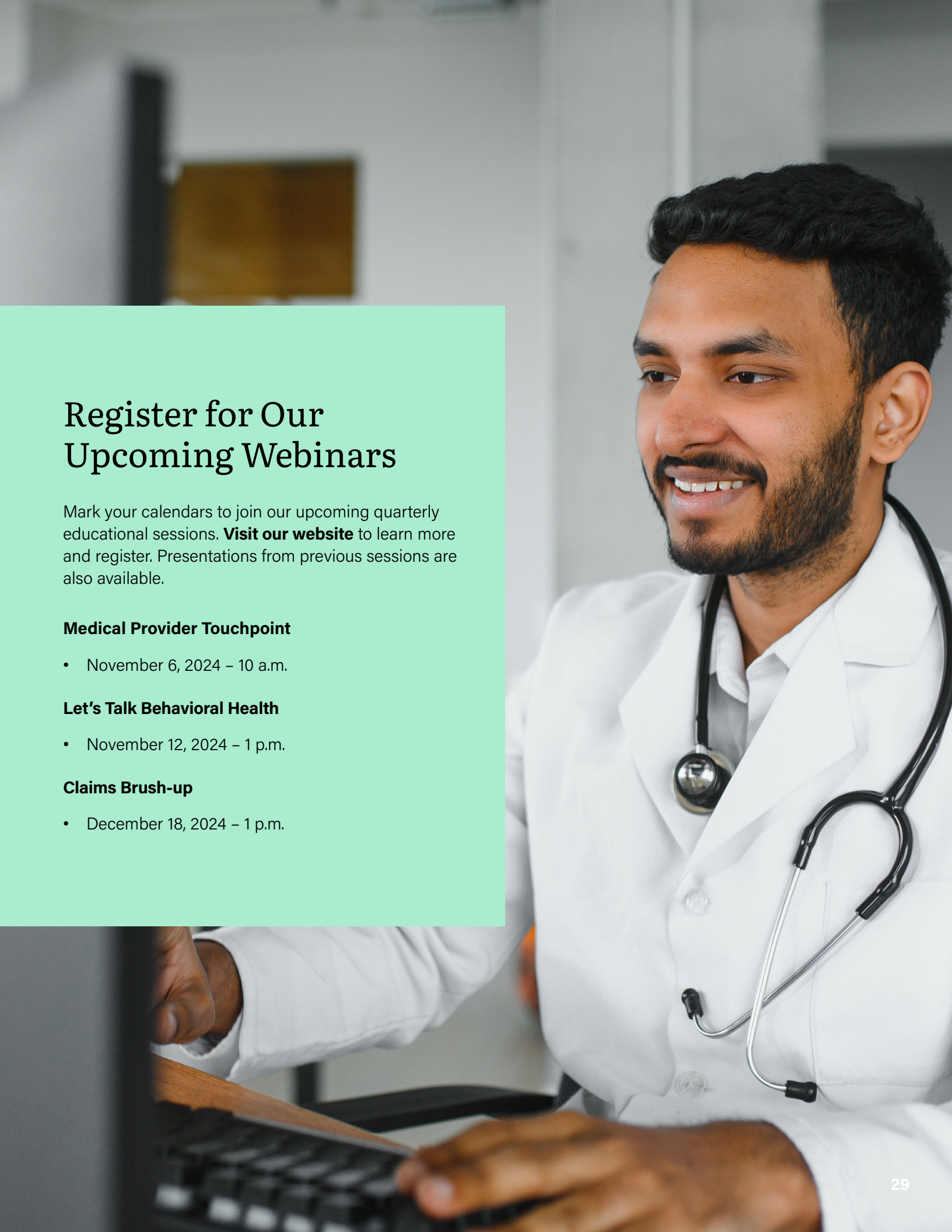
Formulary updates for our commercial, exchange, FAMIS, Medicaid, and Medicare lines of business can be found on our **website**.

Once at the '**Formularies and Drug Lists**' page, choose the appropriate line of business. **The 'Quarterly Pharmacy Changes' document(s) are updated quarterly.** Updates are posted a minimum of 60 days prior to implementation.

Sentara® Health Plans

Important Updates and Reminders

- Register for Our Upcoming Webinars



Register for Our Upcoming Webinars

Mark your calendars to join our upcoming quarterly educational sessions. **Visit our website** to learn more and register. Presentations from previous sessions are also available.

Medical Provider Touchpoint

- November 6, 2024 – 10 a.m.

Let's Talk Behavioral Health

- November 12, 2024 – 1 p.m.

Claims Brush-up

- December 18, 2024 – 1 p.m.