

Oregon

2025 Provider Workshop



Welcome

Agenda

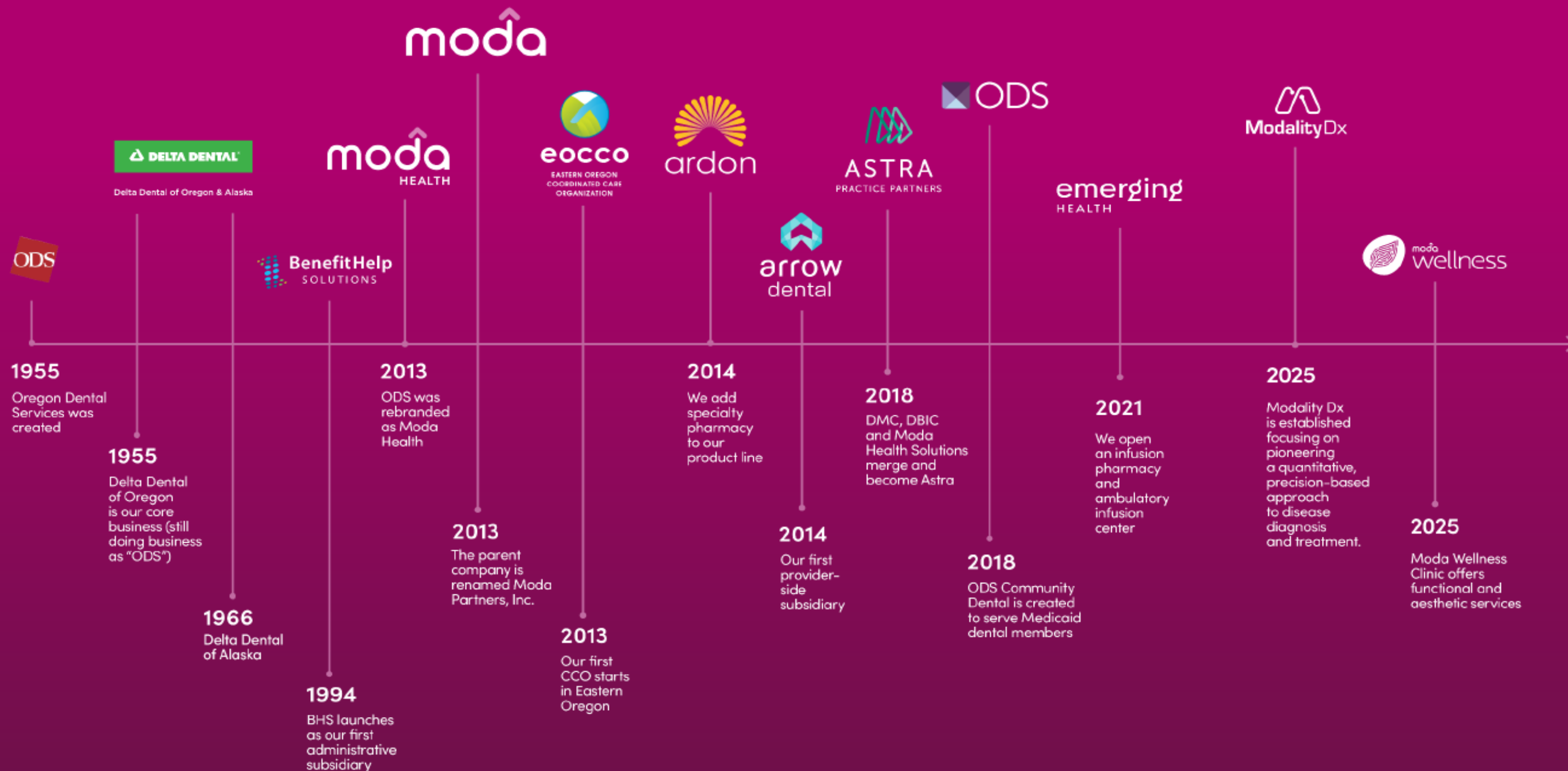
- Diversity, equity and inclusion (DEI)
- Credentialing vs. Contracting
- Commercial networks/benefits
- Claims/billing
- Prior authorizations
- Appeals
- Healthcare services
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Provider resources



Trusted
partner
since

1955

The Moda Family of companies: Strength in diversification



Diversity, equity and inclusion survey

Diversity

We value, respect and celebrate people of all backgrounds, identities and abilities. And we actively seek to identify how uniqueness makes us better.

Equity

We strive to understand the underlying causes of outcome disparities and actively work to increase justice and fairness in our processes, procedures and systems. We do this within our company and within our communities.

Inclusion

We are committed to creating environments where every individual has an equal opportunity to belong and can be recognized for their inherent worth and dignity.



DEI survey

Currently, diversity among physicians is limited. Mounting evidence suggests that when physicians and patients share the same race or ethnicity, it improves:

- Time spent together
- Shared decision-making
- Wait times for treatment
- Screening adherence
- Patient understanding of health risks
- Patient perceptions
- Treatment decisions

We invite you to share your demographic information with us.

[Moda Companies - Provider Data for Diversity, Equity and Inclusion](#)

Credentialing vs. Contracting



Credentialing vs. Contracting

Credentialing

This process allows Moda to vet the providers education, licensure, insurance and specialty. Verifying that the information is accurate and up to date.

Contracting

This process allows our Provider Configuration and Update team to add the necessary and contracted participating networks to the provider's profile, which drives claims processing.

Our Join the Moda network page lays out how to begin the process of joining Moda as a participating provider

[Join the Moda Health medical provider network](#)

Our Credentialing page lays out how to begin the process of credentialing with Moda

[Moda Health Medical providers | Credentialing overview](#)

Our networks page lays out each network, where the participation is and a list of some provider groups participating in those networks

[Plan types](#)

Commercial networks

2025-2026 Commercial networks



Group

2025-2026 Commercial networks

Connexus

- Statewide PPO plan
- PCP selection, referrals not required
- OEGB

Synergy

- Coordinated care plan for employer groups
- Only OHSU & PEBB

Moda Select

- Exclusive Provider Organization
- Currently available in three counties (Multnomah, Washington and Clackamas)
- PCP selection required

Group

2025-2026 Commercial networks cont.

OHSU PPO

- OHSU employee plan
- Tiered benefits
- Provider participation determined by OHSU

OHSU EPO

- OHSU employee plan
- Tiered benefits; no out-of-network coverage
- Provider participation determined by OHSU

HMC & OHSU Health

- Hillsboro Medical Center employee plan
- Provider participation determined by Tuality/HMC

Group

2025-2026 Networks

Asante Health Network (AHN)

- Asante Health employee plan
- Tiered benefits
- Provider participation determined by Asante Health

Connexus PeaceHealth Network

- PeaceHealth & ZoomCare employee plans
- Tiered benefits
- Provider participation determined by PeaceHealth & ZoomCare



zoomcare



Individual

2025-2026 Networks

Affinity

- Individual Exclusive Provider Organization plan sold in/out of the exchange
- Statewide

Commercial group networks



Connexus

Small and large group plans

Connexus Network

- Statewide PPO network
- No PCP/Medical Home selection required
- Member can see in-network providers in all counties in Oregon and some areas of Washington and Idaho
- Multiple participating health systems

Synergy

Synergy Network

- Synergy members need to select a PCP to receive Tier 1 benefits
 - Each family member makes their own selection
- PEBB Synergy members must pick a “PCP 360” provider
- Member can see in-network providers in all counties in Oregon and some areas of Washington and Idaho

Moda Select

Small and large group plans

Moda Select

Sunsetting for Oregon on 12/31/2025

- Exclusive Provider Organization (EPO)
- PCP Selection is required
- No out-of-network benefits
- Group members residing in Clackamas, Multnomah and Washington counties, until 12/31/2025
- Texas and Idaho

OHSU

OHSU network

OHSU PPO

- Tier 1 benefit plan for OHSU employees only with statewide participation determined by OHSU (closed panel)

OHSU EPO

- Tier 1 benefit plan for OHSU employees in the Portland Metropolitan Area (closed panel)

HMC – Hillsboro Medical Center & OHSU Health Employee Plan

- HMC employee plan, aka Tuality Health and Associates (closed panel)

Asante Health

Asante Health Network

Asante

- Tier 1 benefit plan for Asante employees only with participation determined by Asante Health (closed panel)
- Tier 2 benefit plan for employees (closed panel)
- OON benefits available



PeaceHealth

PeaceHealth Network

PeaceHealth & ZoomCare

- Tier 1 benefit plan for PeaceHealth & ZoomCare employees only with participation determined by PeaceHealth (closed panel)
- Tier 2 benefit plan via Connexus network (regular panel availability)
- Tier 3 is out of network

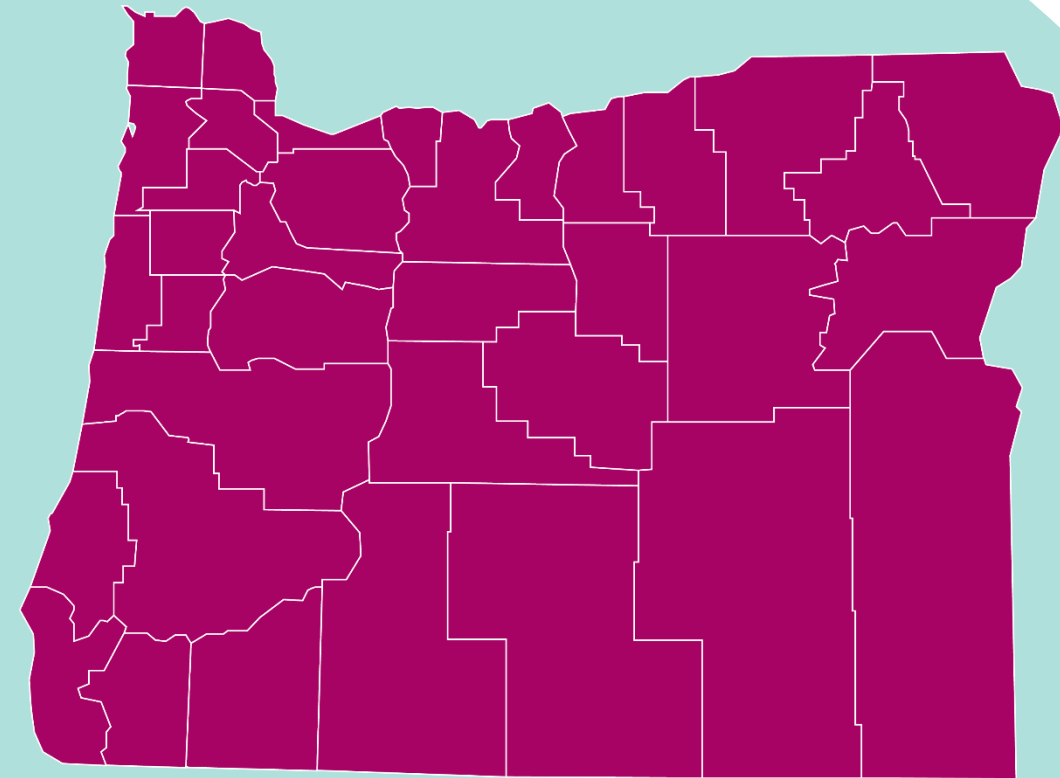
Individual network



Affinity

What is the Affinity Network?

- Clinically integrated network, which includes 15 health system partners and their referring providers
- PCP selection is required
- Exclusive Provider Organization (EPO)
- No out-of-network benefits



Membership numbers

Total Oregon members: 477,504

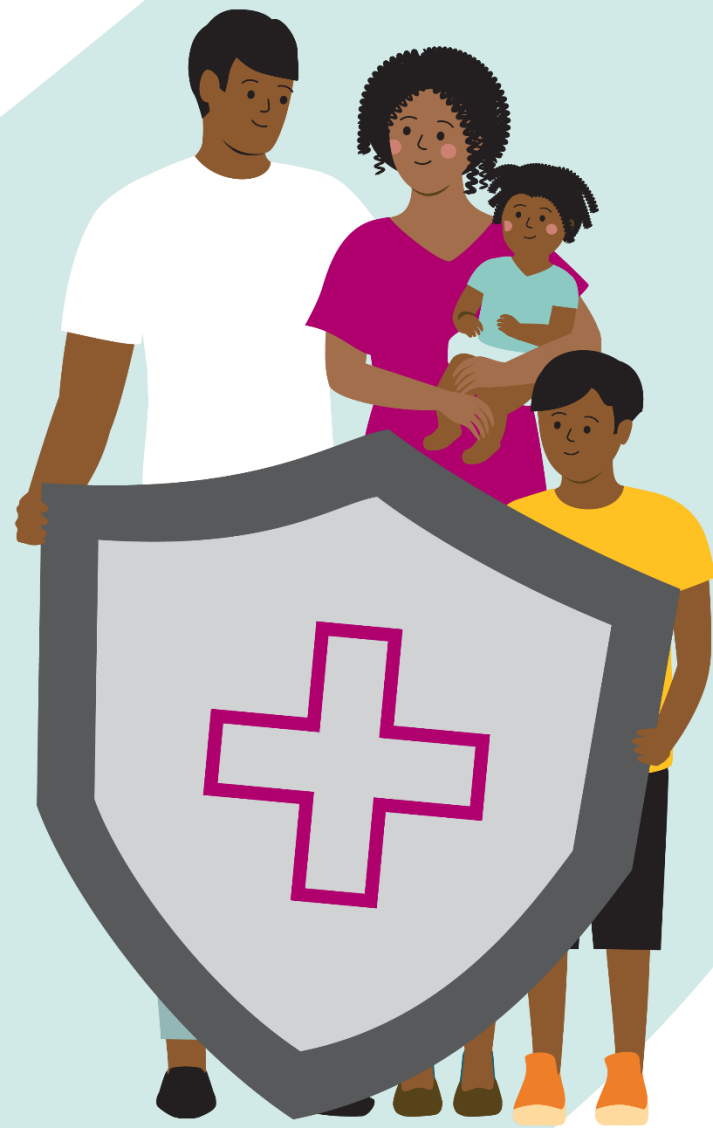
Networks

- Connexus: 89,202
- Affinity: 31,935
- Synergy: 1,112
- Tuality PPO (HMC): 1,761
- OHSU EPO: 5,536
- OHSU PPO: 29,223
- Salem Health: 8,414
- Asante Health: 82,683
- PeaceHealth: 89,984
- Medicaid: 137,654



Commercial benefit updates





Commercial benefit updates

OEBB

- Effective 10/01/2025: moving to Site of Care program through EviCore.

PEBB

- Effective 01/01/2026: Pharmacy benefit change, which mandates mail order for 90-day fills.

Affinity

- No changes for the 2026 plan year.

Claims and billing



Telehealth and telemedicine expanded services

Moda Health's website has the most up-to-date reimbursement policy for telehealth/telemedicine:

- [Telehealth And Telemedicine \(modahealth.com\)](https://modahealth.com/telehealth-and-telemedicine)
- [Telehealth and Telemedicine Expanded Services for COVID-19 – Updated for Public Health Emergency Ending \(modahealth.com\)](https://modahealth.com/telehealth-and-telemedicine-expanded-services-for-covid-19)



New telehealth code set 2025

Moda is accepting the new code set of 98000-98007 for 2025.

Billing with the add-on code of G2211 means you must bill with the code set 99202-99215 with POS 02 or 10.

Below is a link that is published on the CMS website that goes into further detail on billing with the add on code of G2211.

[MM13473 - How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211](#)



Scope of license – Evaluation & management

Our clinical edit system includes edits to ensure procedure codes with specific requirements are reported by appropriate providers. There are edits to address a variety of procedure codes to determine if the billing provider's scope of license does or does not encompass the key responsibilities required for the billed services.

Qualifying provider types for E/M services include:

- Physicians
- Physician assistant (PA)
- Advanced practice nurses
- Pharmacists for Oregon Commercial and Medicaid plans only

[Scope of License for Evaluation & Management Codes](#)

[NPPES NPI Registry](#)

Drugs and biologicals discard and waste

CMS requires providers and suppliers use the JW modifier on all claims for separately payable drugs with discarded drug amounts from single-use containers separately payable under Part B.

When submitting claims, providers must indicate the units of the drug that were discarded using the JW modifier on a unique line.

Use of the JZ modifier is required on claims for drugs from single-dose containers when there are no discarded amounts.

*Please note that medical records must support drug wastage when billed. Documentation requirements are outlined in Moda Reimbursement Policy RPM015 “Modifiers JW & JZ – Drugs and Biologicals, Wastage and/or Discarded Amounts.”

[Modifiers JW & JZ – Drugs and Biologicals, Wastage and/or Discarded Amounts](#)

[Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy](#)

Time-based codes

Procedure codes with descriptions that specify an increment of time such as minutes or hours are “time-based procedure codes.” For all time-based services, the duration of the service must be clearly documented in the medical record with either a) begin- and end-times listed or b) the specific total number of minutes and hours the service was performed.

If more than one time-based service/procedure code is billed for the same date of service, the medical record must separately document the time for each distinct time-based service. Documenting the total time spent with the patient is not sufficient to support the multiple time-based codes billed. Please ensure documentation is complete for each service billed to avoid issues if the claim is reviewed to validate the billed procedure codes.

<https://www.modahealth.com/-/media/modahealth/shared/Provider/Policies/RPM039.pdf>

Common time-based code examples

Multiple physical medicine (PT) modalities

Neurobehavioral status exam (96116, Psychological or neuropsychological test administration/scoring (96136/96137) and Neuropsychological testing evaluation (96132/96133).

<https://www.modahealth.com/-/media/modahealth/shared/Provider/Policies/RPM039.pdf> (see section E, Time-based services)

<https://www.apaservices.org/practice/reimbursement/health-codes/testing-code-faq.pdf> (see page 2)

<https://www.apaservices.org/practice/reimbursement/health-codes/testing/billing-coding-addendum.pdf>

Unlisted procedure codes

Selecting procedure codes, unlisted codes-

Report the most specific code that accurately represents the service, procedure or item provided. Do not select a code that merely approximates the service or item provided. Unlisted codes should only be used when there isn't an established code to describe the service, procedure or item provided. If an unlisted code must be used, select the most specific unlisted code available.

When unlisted codes are reported, a description must be included on the claim. Supporting documentation and explanations should be attached as appropriate. The absence of a description for an unlisted code is a billing error.

<https://med.noridianmedicare.com/web/jfb/topics/claim-submission/submission-errors-solutions/unlisted-procedure-and-noc-codes>

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf>

[Commercial provider manual](#) (see page 41)

Unlisted code examples

For electronic claims:
The description can be placed in the Line Level Procedure Code Descriptions field. For example:

Line Level Procedure Code Descriptions		
Line 1	Code and Mods: 31299	Description: PR ENDSB RESECT MCF PARASELLAR EXTRADURAL

Comparable code information can be included in the Claim Notes Additional Information field. For example:

Claim Notes		
:		
Line 1	Additional Information:	ENDOSCOPIC MIDDLE CRANIAL FOSSA RESECTION EXTRADURAL 61607

Alternatively, all information may be able to fit in the Line Level Procedure Code Descriptions field.
For example:

Line Level Procedure Code Descriptions		
Line 1	Code and Mods: 31599 51	Description: ADAM'S APPLE REDUCTION - UNLISTED 31599 - COMPARABLE TO CPT 31400 WITH EQUAL COM

Claims

Clinical edits — clinical editing systems

- Professional claims — professional clinical edits, Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUE)
 - Practitioner PTP edits apply to ASCs
- Facility claims — outpatient hospital CCI, PTP and MUE edits
- Claims exempt from Outpatient Prospective Payment System (OPPS) edits, status indicators and rules
 - Critical Access Hospitals (CAH) – Type of Bill 085x
 - Rural Health Clinic (RHC) – Type of Bill 071x
 - Federally Qualified Health Center (FQHC) – Type of Bill 077x

modahealth.com/pdfs/reimburse/RPM002.pdf

Claims

National Correct Coding Initiative (NCCI) links

- MUE information: [_cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE](https://cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE)
- PTP coding edit information: cms.gov/medicare/coding/ncci-edits/procedure-procedure
- NCCI FAQ: cms.gov/medicare/national-correct-coding-initiative-edits/ncci-faqs
- [Medicare NCCI Correspondence Language Manual | CMS](#)

Claims

ED leveling

Moda Health reimburses emergency department (ED) professional evaluation and management (E/M) services based on the level of acuity, complexity and severity.

Reimbursement determinations are based on:

- Medical necessity/utilization criteria
- The patient's primary discharge diagnosis
- The patient's age

[ED-Leveling-MHMNC.pdf \(modahealth.com\)](#)

[Emergency Department Visit Leveling \(modahealth.com\)](#)

Claims

Corrected claims

When billing corrected claims to add additional services, include the original services that may have already paid. The entire bill including corrections must be submitted.

Example: Changing modifiers, procedural codes, diagnosis, dates, units or other information.

Claims must be clearly identified in one of the following ways-

- 1) Submit a corrected claim electronically via a clearinghouse.
 - a. Facility Claims (UB): Box 4 (7 = replacement or corrected; 8 = voided or cancelled) Original Claim Number.
 - b. Professional Claims (CMS): Box 22 on CMS 1500 (7 = replacement or corrected; 8 = voided or cancelled)

Submit a corrected paper claim to:

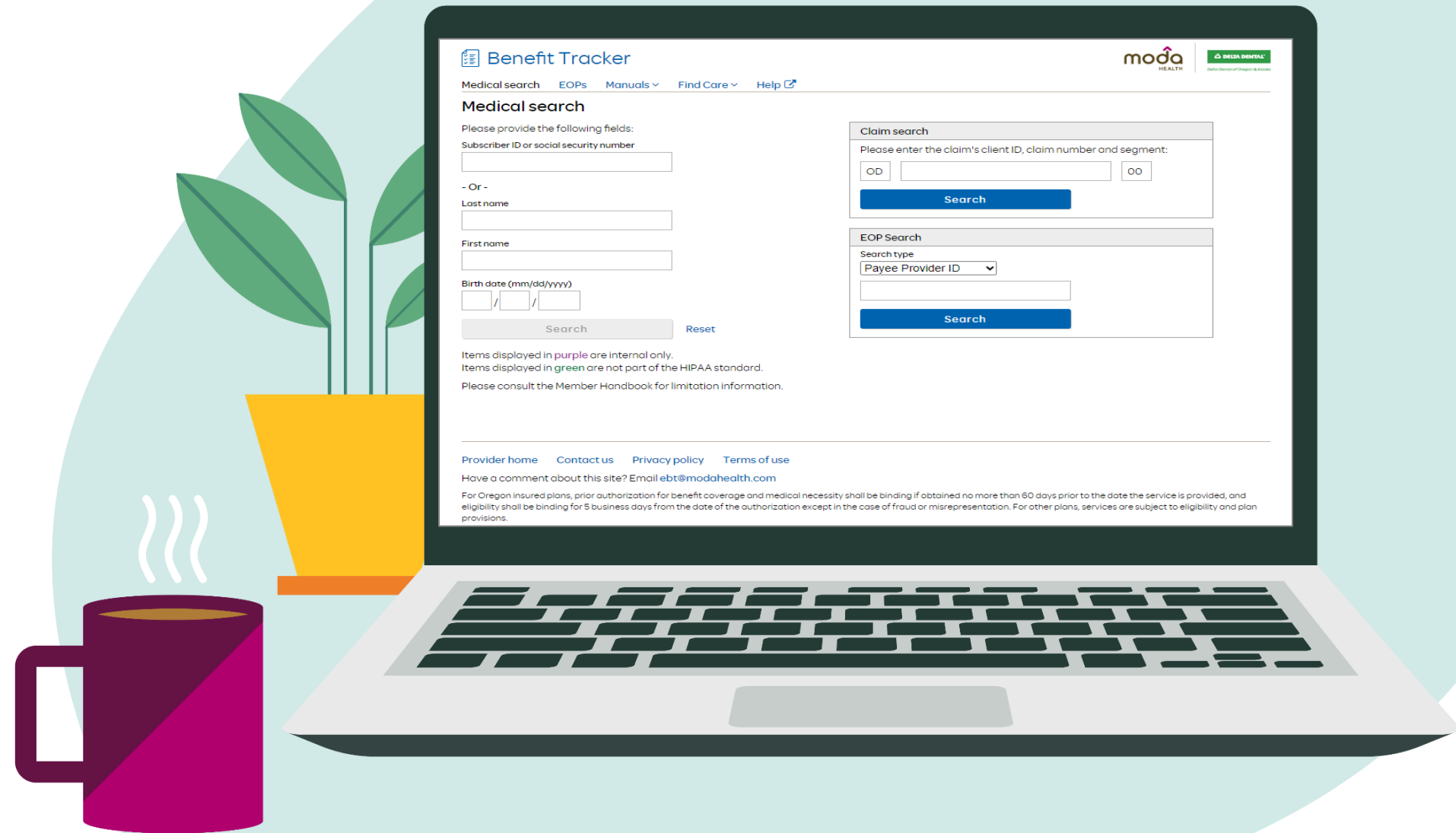
Moda Health Attention: Corrected Medical Claims

P.O. Box 40384 Portland, OR 97240

Fax #: 855-522-9810

Claims Benefit Tracker

- Access Benefit Tracker from two platforms:
 - Moda Health — modahealth.com/medical/mbt.shtml
 - OneHealthPort — onehealthport.com/sso
- Access to detailed patient benefit information
- Search by Member ID#, SSN, first or last name and DOB
- Our website has additional information that OneHealthPort may not capture
- Login required for each site
- Information and questions, email or call ebt@modahealth.com or 877-277-7270



Contacting Moda Health

Medical Customer and Provider Services

Please start with our Medical Customer Service team for any claim issues or inquiries:

medical@modahealth.com or 503-243-3962.

If Customer Service is unable to resolve your escalated claim inquiry, or if you have a contract interpretation question, please contact providerrelations@modahealth.com or your assigned representative.

Provide the following information via email:

- Customer Service Tracking (CST) number
- Claim numbers or member ID and date of service
- Any supporting documentation or correspondence



Prior authorizations



Prior authorizations

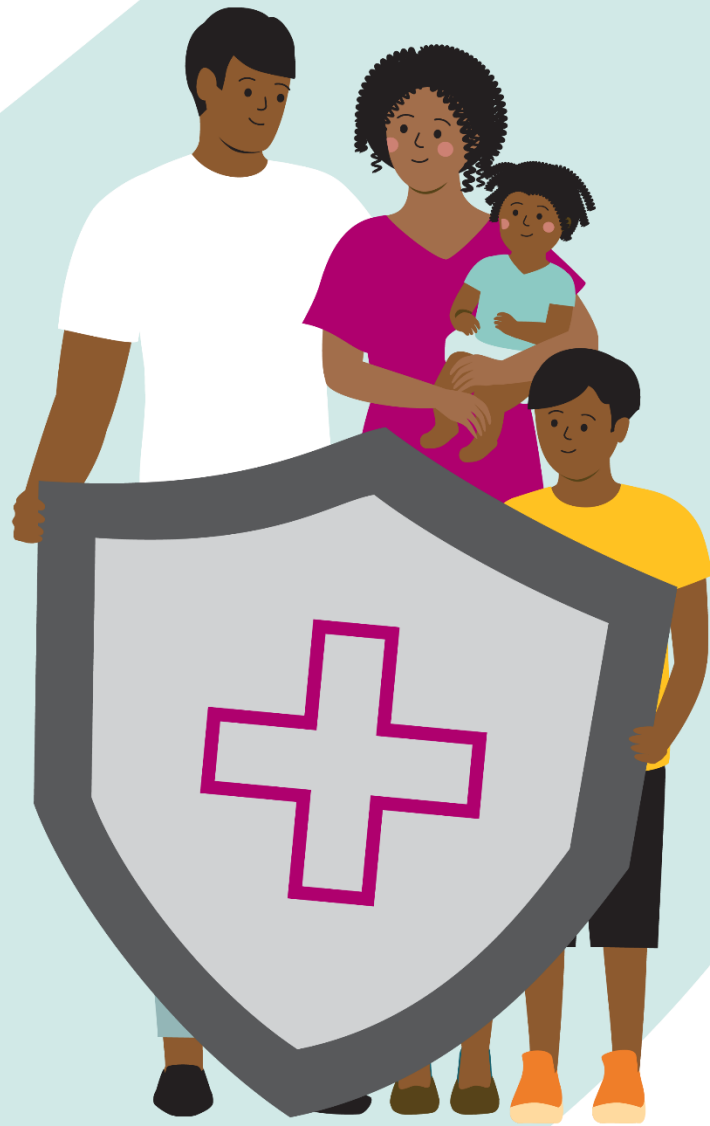
How to determine that a service requires prior authorization:

- Review referral and authorization guidelines based on the line of business
- Review “Always Not Covered” list
- Access prior authorization forms

Failure to get prior authorization when required may result in claim denial. Members cannot be balance billed.

- *Note: Prior authorizations are not required. Moda Health is not the primary payer

modahealth.com/medical/referrals/



 Exciting change! You can now submit prior authorizations through our Auto Authorization Application in Benefit Tracker. To submit, select Medical Benefits and click on the section titled Prior Authorization.

[Back to Medical search](#)

Prior authorization

[Medical benefits](#) | [Vision benefits](#) | [Pharmacy benefits](#) | [Claims](#) | [Referrals](#) | [PCP history](#) | [EOBs](#) | [Member handbook](#) | [Prior-Authorization](#)

Review our Auto Auth Application How To Guide for information on how to submit a request:
[Commercial Auto Auth Application How To Guide](#)

Medical prior authorization

Patient information

Patient name:	Insurance Type:
Date of birth:	Group number:
Subscriber ID:	Group name:

Please be sure to review the Prior Authorization list for the services being requested to confirm the requested service require authorization before proceeding.

 [Commercial prior authorization list](#)

[Create new request](#)

Prior authorizations

Medical provider
overview

Benefits & eligibility

Authorization & referrals

Referral and
authorization guidelines

Advanced Imaging and
musculoskeletal
utilization management
programs

Injectable medication
program

Claim edits policy

Medical necessity criteria

MCG®

Site of care

Referral and prior authorization guidelines

To help you understand what services need prior authorization, Moda Health provides these prior authorization lists.

Submit your prior authorization request electronically

- [Commercial Auth Application How To Guide](#)
- [Medicare Auth Application How To Guide](#)

Service Authorization Request Requirements

Make sure the prior authorization request is complete and contains:

- All pertinent member information (name, ID #, group #, and member's birth date)
- PCP information (name, TIN, phone, fax and contact name)
- The name and TIN of the facility where the procedure is to be performed
- The date of the procedure or date of admission
- Surgeon's or specialist's full name and TIN
- CPT & diagnosis codes must be included
- Length of stay (indicate if inpatient)
- Chart notes

Benefit Tracker

Check benefits and eligibility

[Log in](#)

[Account help](#)

[Request an account](#)

Provider Reports

For value-based provider programs, including Synergy, Summit, Beacon, Affinity, CPC+, and EOCCO

[Log in](#)

Join our email list

[Sign up](#)

Please refer to these documents to help you determine if your patient needs a prior authorization:

Group/Individual

- [electronic Rx Prior Authorization Portal](#)
- [Commercial Prior Authorization List](#)
- [Group/Individual always not covered list](#)
- [Referral/Authorization - Commercial only](#)
- [Behavioral Health Authorization Request Form](#)
- [OHSU Employee Massage Therapy Request Form](#)

[Referral and Authorization Guidelines](#)

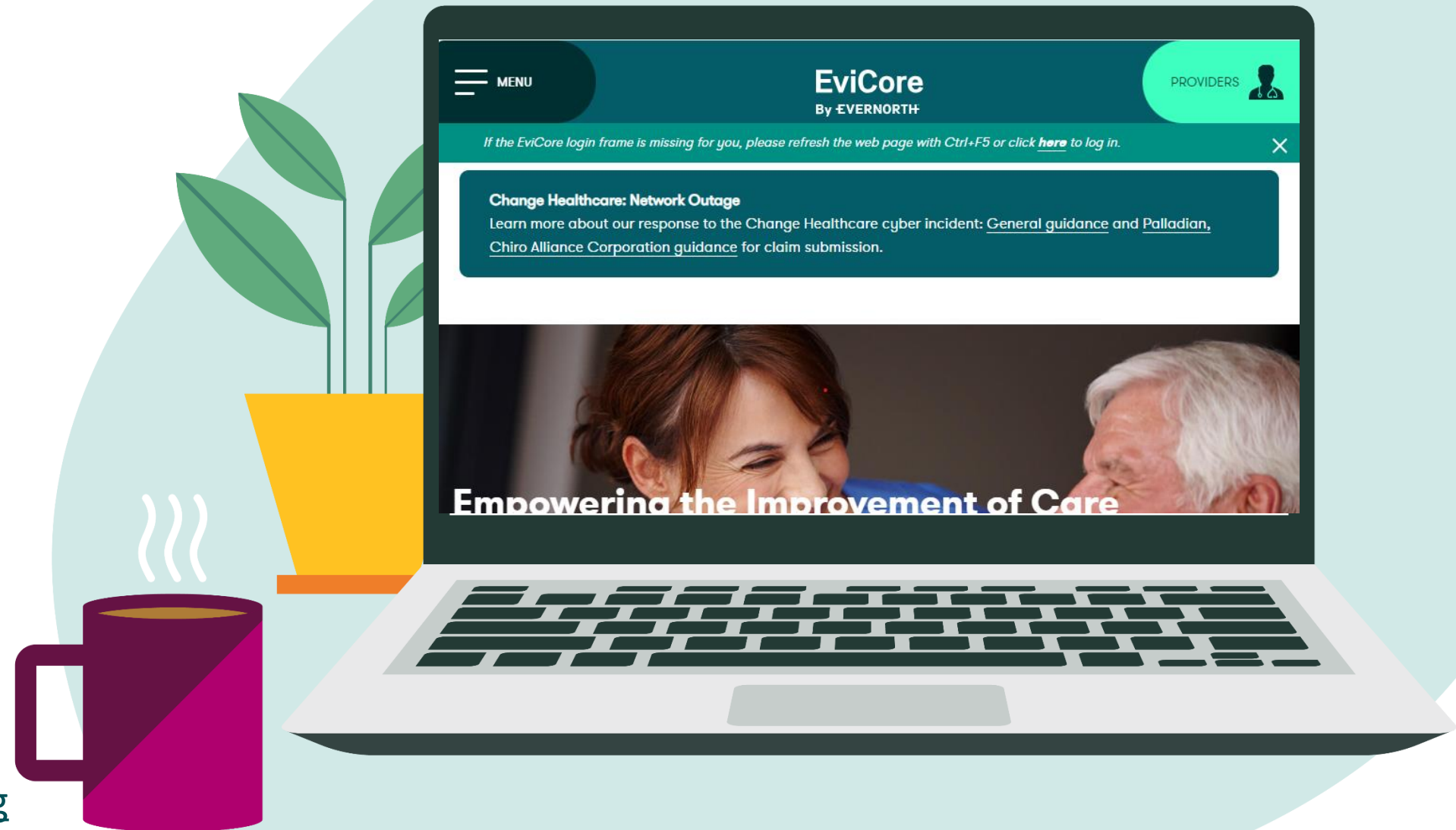
Prior authorizations

EviCore reviews authorization requests for the following services:

- Advanced imaging
- Musculoskeletal therapies
- Pain management
- Spine and joint surgery

Services that require prior authorization through eviCore are listed on our website:

modahealth.com/medical/utilizationmanagement.shtml





Prior authorizations

Check Benefit Tracker to determine if the member’s plan uses EviCore, and for what services.

-This can be found on the main benefit page
(in red)

Benefit information

Select for benefit details:

☒ Primary Care

☐ Not My Moda Medical Home

☐ In-Network

☐ Out of Network

Select a category ...

Benefit period:	Contract
Pre-existing months ⁴ :	0
Dependent stop age:	26
Student stop age:	26
Domestic partner:	Coverage for Domestic Partners may or may not apply. Please check with your participating entity to see if this coverage is available.
Referrals:	Referral is not required.
Authorizations:	• Phone: 503-243-4496 • Toll Free: 1-800-258-2037 • Fax: 503-243-5105 Plan has eviCore for the following services: Advanced Imaging, Cardiology, Spine/Joint, Pain Management, PT/OT/SPT, Chiropractic and Acupuncture. <u>Evicore - Authorizations</u> • Phone Number: (844) 303-8451 • Website: www.evicore.com

Clinical guidelines

Provider's Hub

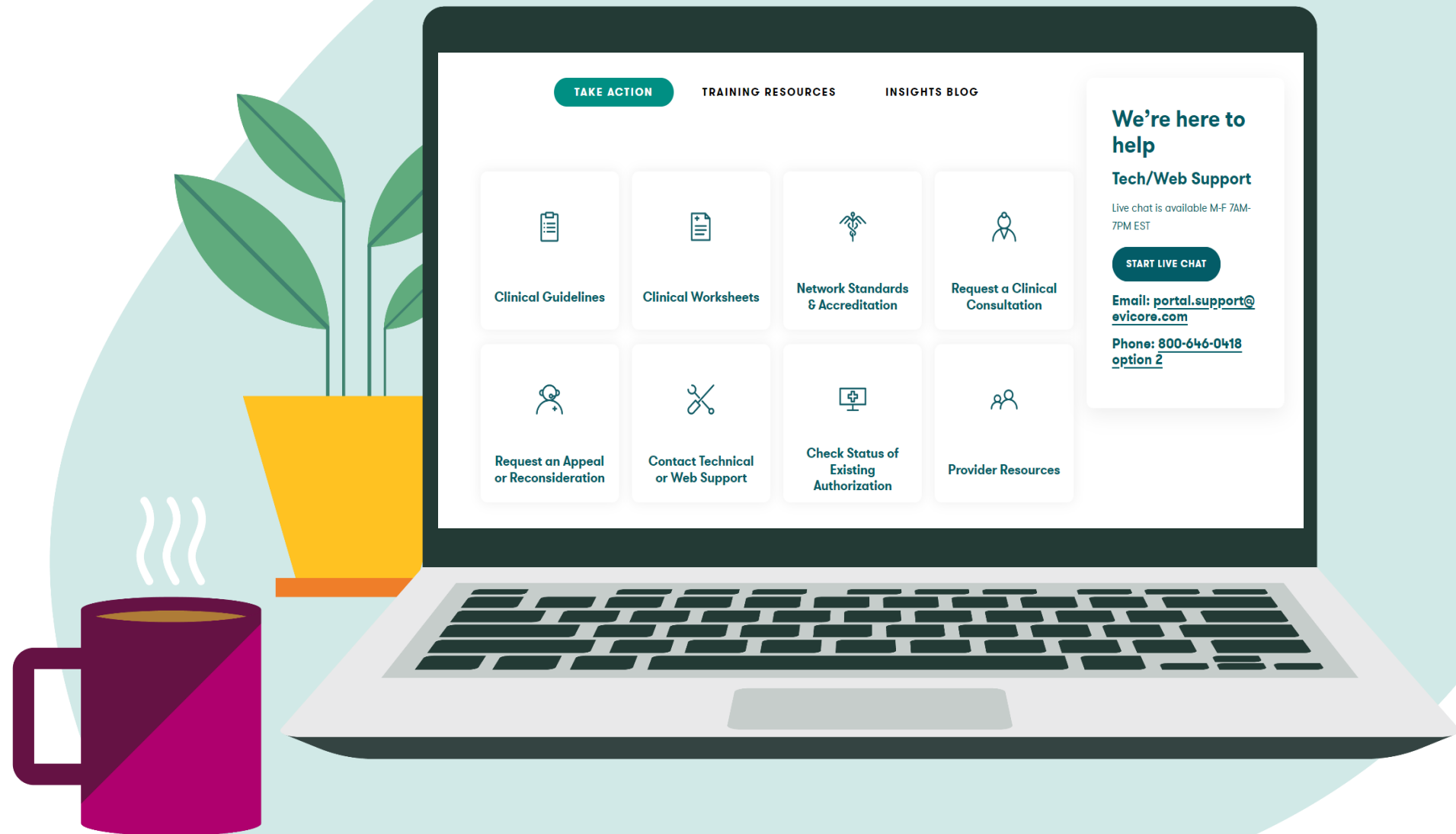
Clinical guidelines/worksheets can be accessed before logging in to the portal

Resources

- Training resources
- Video tutorials
- How To's
- evicore.com/provider

EviCore also provides “WebEx Training” for new or experienced users twice per quarter for therapies PT, OT and ST
evicore.com/webex.com

Questions? Email clientservices@evicore.com





Clinical guidelines

- Authorization denials
 - Peer-to-peer consultation
 - Can be requested through the provider portal
 - [Request an Appeal \(evicore.com\)](https://evicore.com)
 - Formal appeal
 - Process outlined on denial letter for members and providers
 - modahealth.com/pdfs/evicore_member_denial.pdf



EviCore Newsletter

The newsletter can be helpful in providing the following updates:

- Portal and process news
- Authorization updates
- Reminders
- Provider training opportunities

Stay Updated With Our Provider Newsletter

Your email address

SUBSCRIBE





Prior authorizations

Moda Health contracted providers have access to an online Prime Therapeutics account

- Visit the self-service provider portal at <https://gatewaypa.com/>
- Select “New Access Request-Provider” under “Quick Links” and select “Contact Us” to register

Urgent or expedited request

call 800-424-8114





Prior authorizations

Provider-administered injectable drug program

Prior authorization required for specific injectable specialty medications.

modahealth.com/medical/injectables/

Site of Care program

Certain provider-administered drugs only authorized in outpatient setting or patient's home.

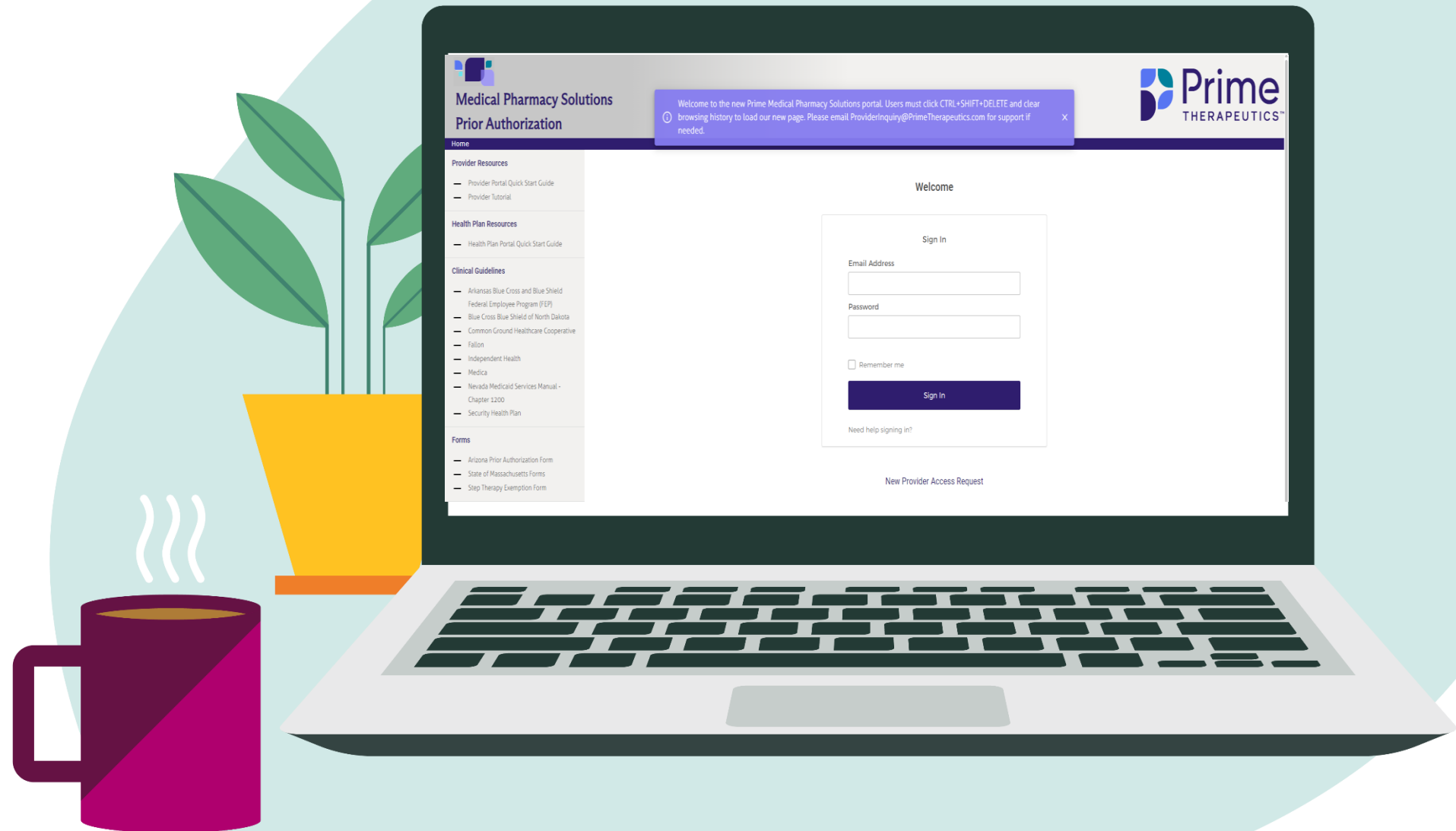
modahealth.com/medical/siteofcare.shtml

Claim edits program

Moda applies post-service pre-payment claims edits to diagnosis criteria and criteria for maximum units for the medications listed in the link below.

[Claims and appeals \(modahealth.com\)](https://modahealth.com/claims-and-appeals)

ProviderInquiry@PrimeTherapeutics.com





Prior authorizations

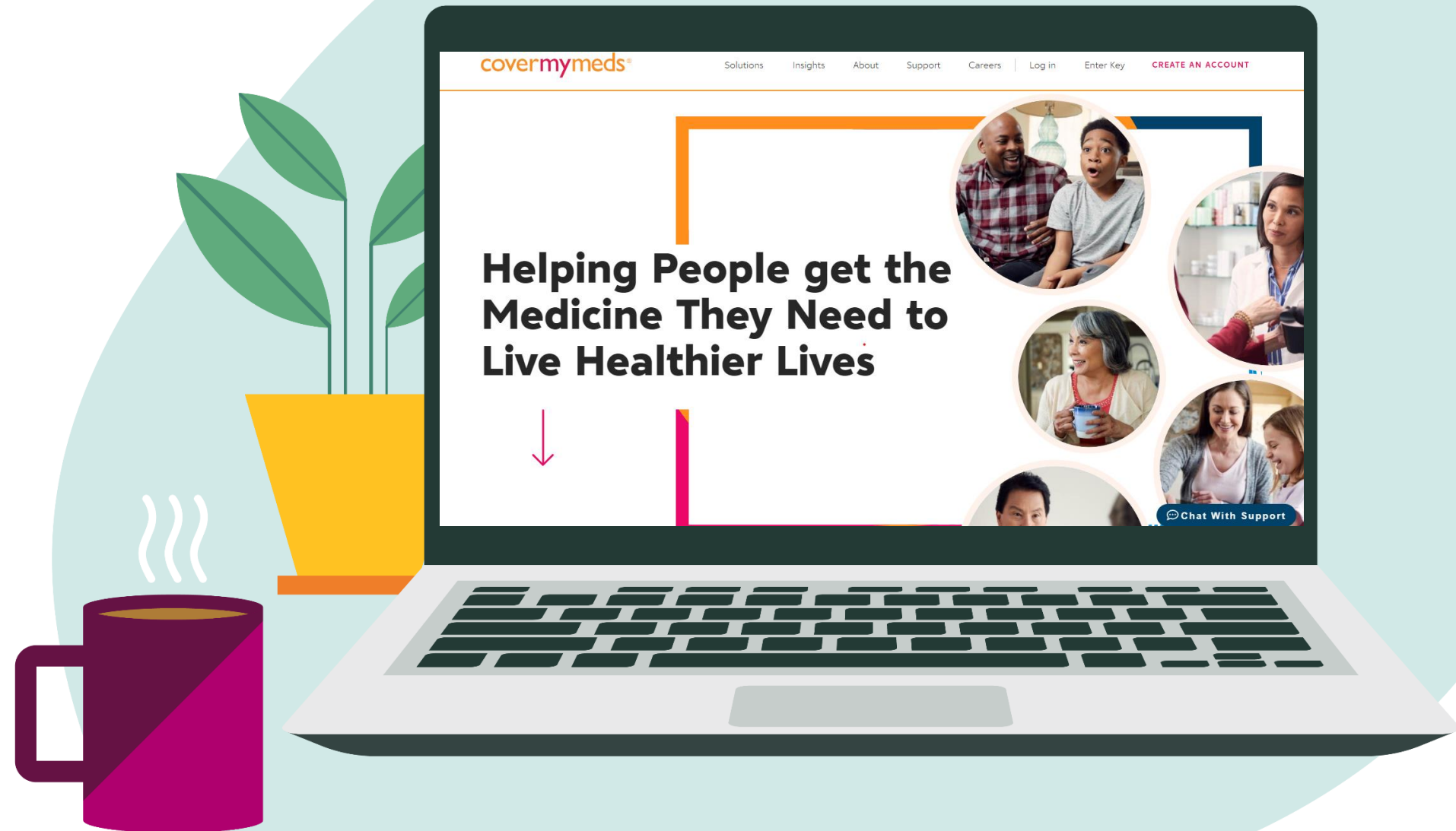
Partnership with CoverMyMeds to process electronic prior authorization (ePA) requests for medications covered under a member's pharmacy benefit

- This free online tool is integrated with all health plans and most large EHR systems
- This does not replace Magellan Rx for injectable medications or Ardon Health for specialty pharmacy

Contact information:

covermymeds.com

Toll Free: 888-361-1610



Appeals



Appeals

Provider appeals

Please contact customer service first for denial inquiries.

If customer service cannot resolve, please follow the appeals process outlined in the provider manual.

Levels of appeal:

- Inquiry
- First-level appeal
- Final appeal



**Moda Health Plan, Inc.
Provider Appeal Unit**

P.O. Box 40384
Portland, OR 97240
Fax: 855-260-4527

How to submit an inquiry

The first time a request for review is submitted to the appeals team, it will always be considered a reconsideration.

A request must be made in writing with the following information:

- Claim status
- Member eligibility
- Payment methodology (including bundling/unbundling, multiple surgery rules, etc.)
- Medical policies (if applicable)
- Coordination of benefits or third-party details

All supporting documentation submitted by the provider will be reviewed, along with the member's benefit plan.

[Commercial provider manual](#)

Appeals

Same specialty request

A same specialty request is a pre-service request by a provider for Moda Health to have a same specialty provider reconsider a prior authorization denial.

- Not necessary to submit new information
- Healthcare Services staff sends the request to Moda's medical consultant for a like-specialty review

Appeals

How to submit a Peer-to-Peer

Although an inquiry and an appeal are considered separate processes, both must be submitted in writing. Please include the following information:

Peer-to-peer

This is a conversation between the requesting provider and the Moda Health medical director. Providers may discuss the denial determination directly with the medical director who made the denial determination, generally this takes place within 10 business days of the denial.

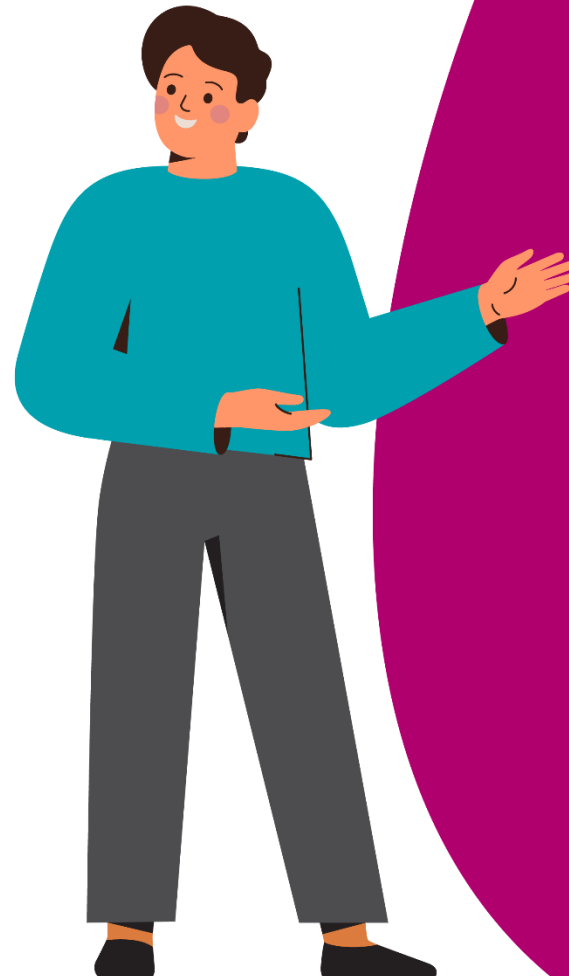
- The consultation is held within 10 days of the pre-service denial
- May give new rationale for the requested service to support medical necessity

Appeals

Medical record requests

We may request medical records and supporting documentation to make decisions on the preceding request.

Medical Records Documentation Standards



Healthcare providers and health plans meet the definition of a covered entity under the **Health Insurance Portability and Accountability Act** and may share information for treatment purposes without a signed patient authorization.

Documentation is necessary to determine the following:

- Medical necessity or appropriateness of a service or supply to be covered
- The standard and/or quality of care or services provided

If the documentation is not provided within the timeframe specified, coverage may be denied.

Appeals

Expedited or rush requests



On receipt of a request, a Moda Health medical director decides whether the request qualifies for an expedited review.



If the medical director qualifies the request, the staff processes it as expedited or rush.



If it is decided that the request does not qualify for expedited review, the staff processes the request using the standard timelines.

Appeals

Member appeals

A member appeal is a pre-service or post-service appeal initiated by a member about an adverse determination on an authorization request or a claim.

- A provider may file a pre-service member appeal on behalf of a member in writing
- The commercial or marketplace member must complete a Moda Health Protected Health Information (PHI) form

modahealth.com/pdfs/auth_provider.pdf

Appeals

Common appeal misconceptions

Prior authorizations

Many services require a prior auth, including anesthesia, dermatology services, etc. If a prior auth could not be obtained ahead of time, providers have up to 14 calendar days to request a retro auth for services. If EviCore or Moda denies a prior auth request as not medically necessary, and you proceed with services anyway, we WILL deny the claim for no auth, services will not be reviewed for medical necessity. The denial will remain upheld.

Hospital audits

When reimbursement is reduced by hospital auditors, that is based on our policies and procedures, and those reductions are never overturned. An appeal will not change that. The Reimbursement Policy the reduction is usually based on is RPM043 Hospital Routine Supplies.

Inappropriate primary diagnosis

We still frequently get appeals for those denials, and they almost never get overturned. The only thing that can help in this situation is a corrected claim, with an appropriate primary diagnosis code. We also need to point out that a letter explaining why the primary diagnosis is in fact valid doesn't change the decision on the denial being upheld.

Healthcare Services





Case management

This service is offered to Moda Health members needing assistance with complex health conditions or catastrophic events.

To make a referral:

Call: 800-592-8283

Fax: 855-232-6904

Email: casemgmtrefer@modahealth.com

Include the following in your referral:

- Member name and ID
- Contact name and number
- Reason for referral

Health navigators

Member health navigators

- Provide health education related to preventive health
- Assist with provider searches, locating community resources, vendor programs, referrals to case management and health coaching

Telephonic health coaches

- Provide in-depth disease management/self-management programs for members dealing with chronic health conditions and diagnoses

To make a referral:

- Call: 855-466-7155
- Email: memberadvocateteam@modahealth.com or healthcoachteam@modahealth.com
- Include the following in your referral:
 - Member name and ID number
 - Contact name and number
 - Reason for referral



HEDIS & Quality Measures



What is HEDIS?

HEDIS® stands for Healthcare Effectiveness Data and Information Set

- Created and managed by the National Committee for Quality Assurance (NCQA)

Rules and requirements are updated annually

HEDIS tracks how well healthcare organizations perform with quality measures across 6 domains:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Electronic Clinical Data Systems (ECDS)



HEDIS Star Ratings

Different organizations produce different overall ratings.

For Moda, the following currently apply:

- **CMS**
- **Marketplace Star Ratings**
- *Individual/Small Group On-Exchange*

- **NCQA**
- **Commercial Health Plan Ratings**
- *Large/Small Group, Individual Off-Exchange*



HEDIS vendors

Cotiviti

- HEDIS engine
- Record retrieval by fax, onsite, mail

KDJ consultants

- Remote EMR retrieval
- 3rd Party “Copy Service” retrieval
- All record abstractions
- Over-reads

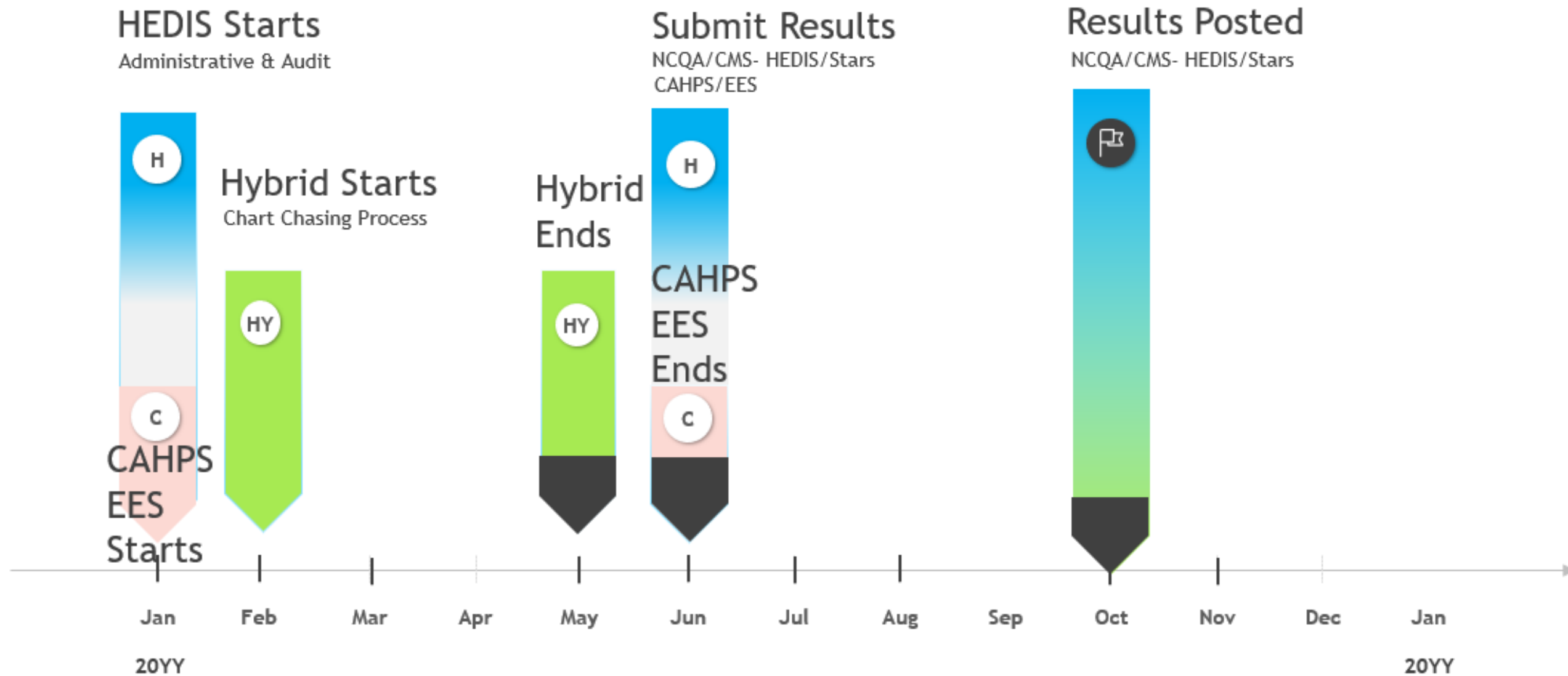
Both Vendors will contact provider offices to arrange for chart collection for Moda HEDIS deliverables.

Questions?

valuebaseddatasharing@modahealth.com



HEDIS timeline



Provider resources



Welcome Moda Health page

- Announcements
- Medical policies
- Authorizations
- Benefit Tracker
- Provider newsletters

[ModaHealth.com | Medical Providers: Welcome](#)

[Medical provider contact us page](#)





Oregon

Contact us

FAQs

Medical provider overview

Benefits & eligibility

Authorization & referrals

Patient care programs

Join our network

Provider resources

Behavioral health

Claims and appeals

Clinical guidelines and tools

Contact us

Directory accuracy

Forms

Medicare compliance

OEBB Reference Price Program

Policies and manuals

Preventive services

Provider news

Samples

Workshops

Patient resources

Pharmacy

Quality of care



Welcome, medical providers

Thank you for partnering with Moda Health. We appreciate your partnership because we know you – like us – are committed to providing our members with the best care.

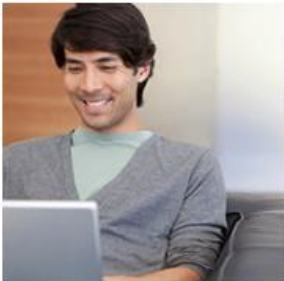
As our valued partner, we want to make sure you have the tools and resources you need to continue providing excellent care.

Benefit Tracker

Moda Health's **Benefit Tracker** is an online resource designed with you in mind. With Benefit Tracker, you have the ability to look up all the information you need, such as:

- Benefits
- Eligibility
- Claims status
- Referrals

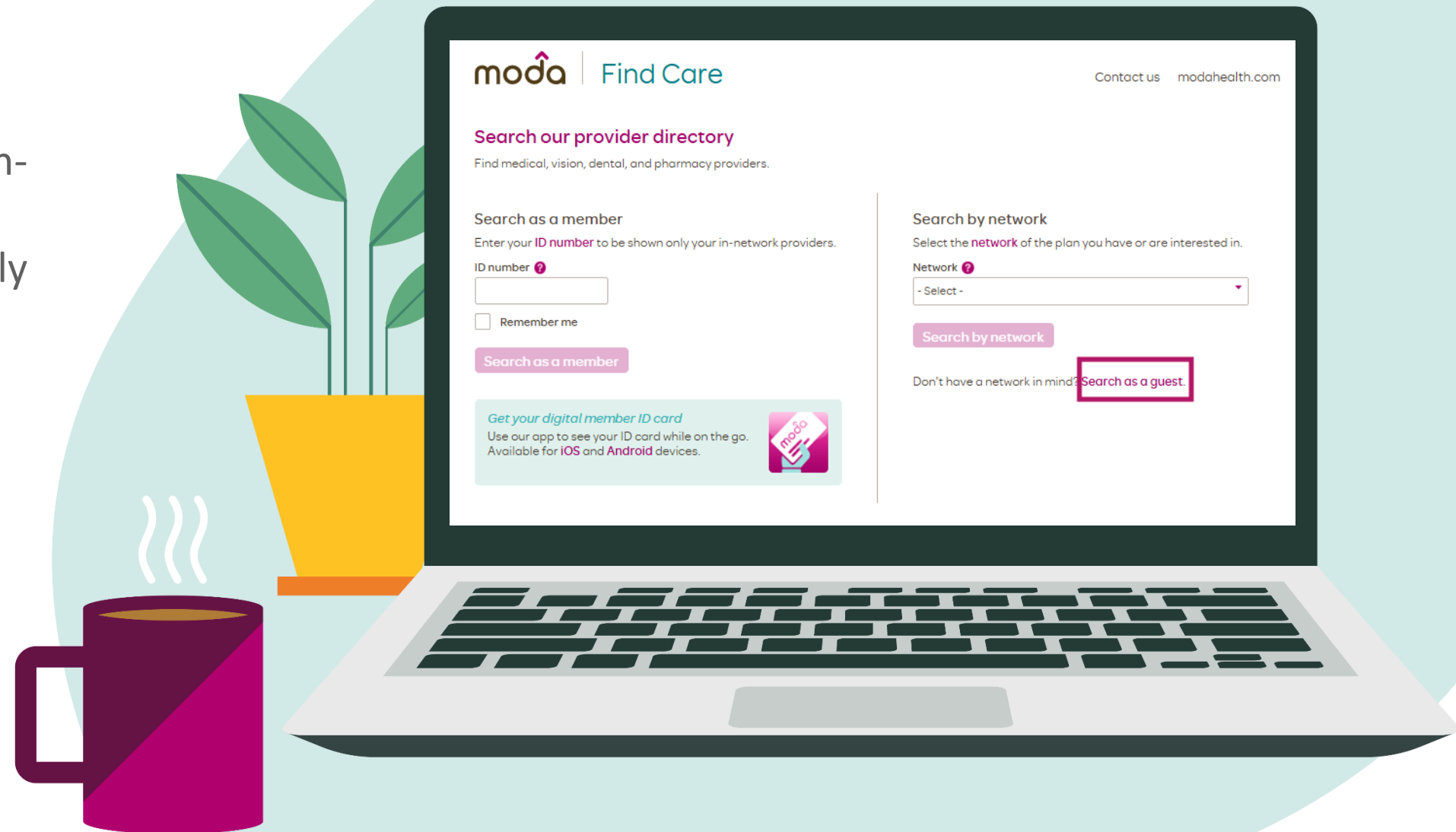
Log in to Benefit Tracker



Find Care directory

This tool allows our members to view in-network, contracted providers. We also ask our providers to periodically check Find Care to confirm your information is displaying accurately.

[Moda Find Care | Search as a guest](#)



Credentialing contacts

Moda utilizes the CAQH ProView site as an application source.

[CAQH Provider Data Management](#)

Contact information:

Call toll-free: 855-801-2993

Fax: 503-265-5707

Email: Credentialing@modahealth.com

Mailing address:

Moda Health

Attn: Credentialing Dept.

601 SW 2nd Ave. #900

Portland, OR 97204

[Moda Health Medical providers | Credentialing overview](#)

Contacting Moda Health

Medical Customer Service

- For questions about single claim inquiry, adjustment request, billing policies and our provider search tool (Find Care):
 - Email: medical@modahealth.com
 - Call: 503-243-3962
 - Toll-free: 877-605-3229

Medical Provider Relations team

- For escalated issues regarding claims, or contract questions
- please send your questions to
 - providerrelations@modahealth.com

Provider updates

- For all demographic changes such as address or practitioner updates or deletions please send to
 - providerupdates@modahealth.com

Electronic Data Interchange (EDI)

- For questions about [electronic claim submission](#), payments and EFT/ERA enrollment [form](#)
 - Email: edigroup@modahealth.com
 - Call toll-free: 800-852-5195



Contacting Moda Health

Authorizations

For questions about referrals and authorizations, and how to submit a request:

- Local: 503-265-2940
- Call toll-free: 888-474-8540
- Fax: 503-243-5105

Contract/fee schedule requests and TIN changes

Email: providerrelations@modahealth.com

Hearing Aid Services/TruHearing

Phone: 866-929-6749 (TruHearing)

866-929-7564 (Moda Health Customer Service)

Vision services/VSP

Phone: 800-877-7195 (VSP),

844-693-8863 (Moda Health Customer Service)



Thank you

