Texas

2025 Provider Workshop

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Welcome

moda HEALTH

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

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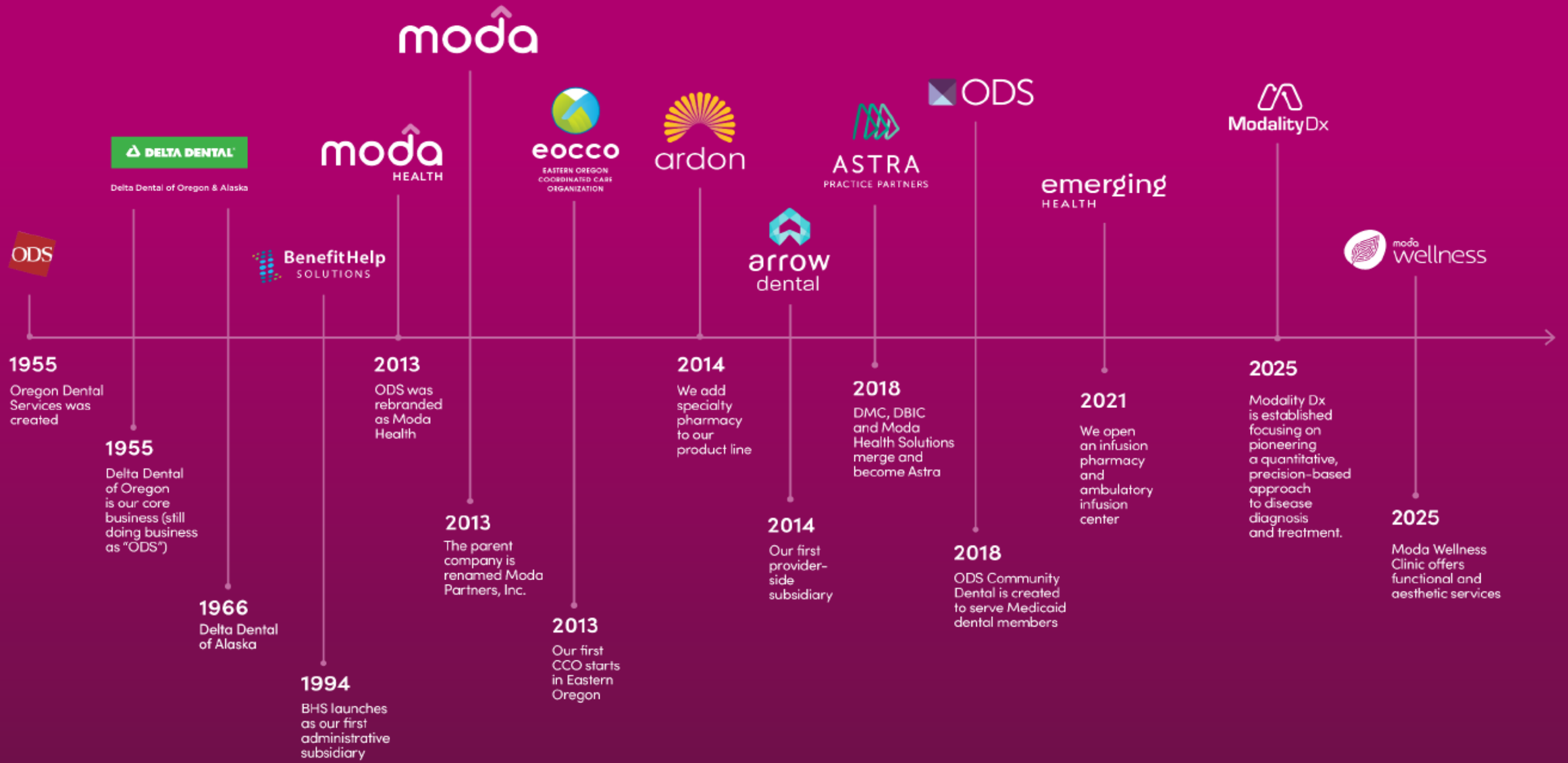
Trusted partner since **1955**

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.

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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

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Credentialing vs. Contracting

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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

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Texas individual network

2025-2026 Commercial Network

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Individual

2025-2026 Commercial Network

Moda Select

- Exclusive Provider Organization
- Available in 3 counties (Hays, Williamson and Travis)
- PCP selection required
- Approximately 4,000 members
- No out-of-network benefit

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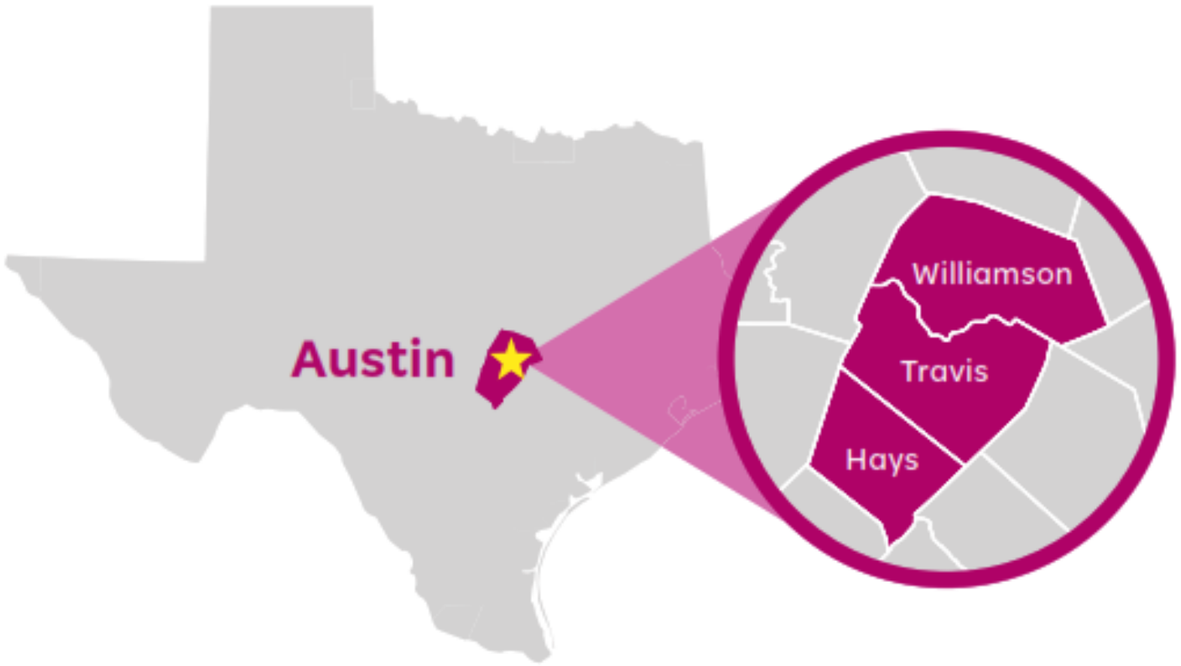
Individual



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Membership numbers

Moda Select total:

- 4,267 members

Numbers by counties:

- Hays: 488 members
- Travis: 2,498 members
- Williamson: 1,281 members

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Claims and billing

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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)
- Telehealth and Telemedicine Expanded Services for COVID-19 – Updated for Public Health Emergency Ending (modahealth.com)

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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

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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

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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

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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

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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

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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)

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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**

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Claims
Clinical edits — clinical editing systems

- Professional claims — professional clinical edits, Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUE) edits
  - 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

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Claims

National Correct Coding Initiative (NCCI) links

MUE information: 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

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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)

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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

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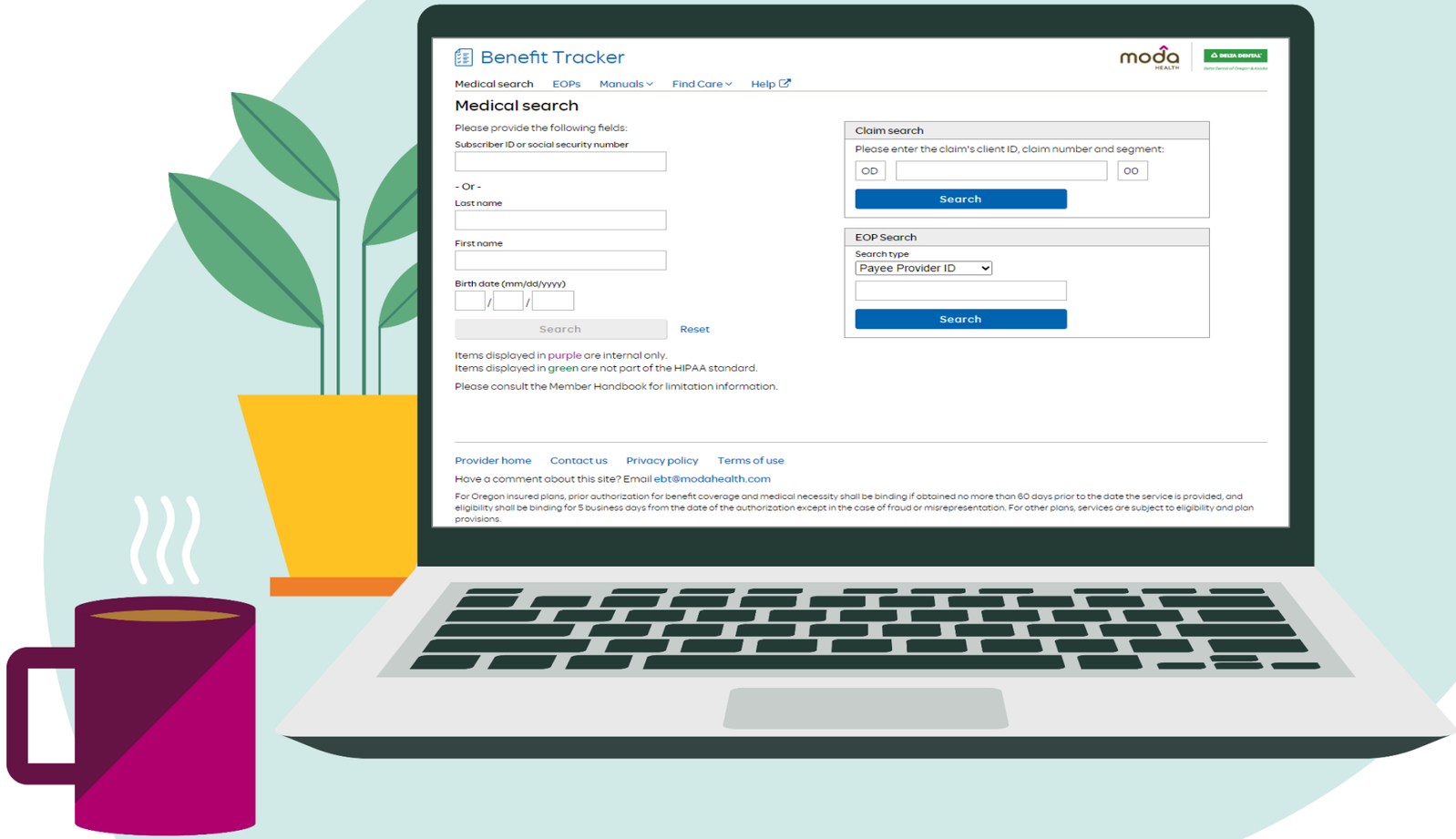
Claims
Benefit Tracker

- 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



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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

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Prior authorizations

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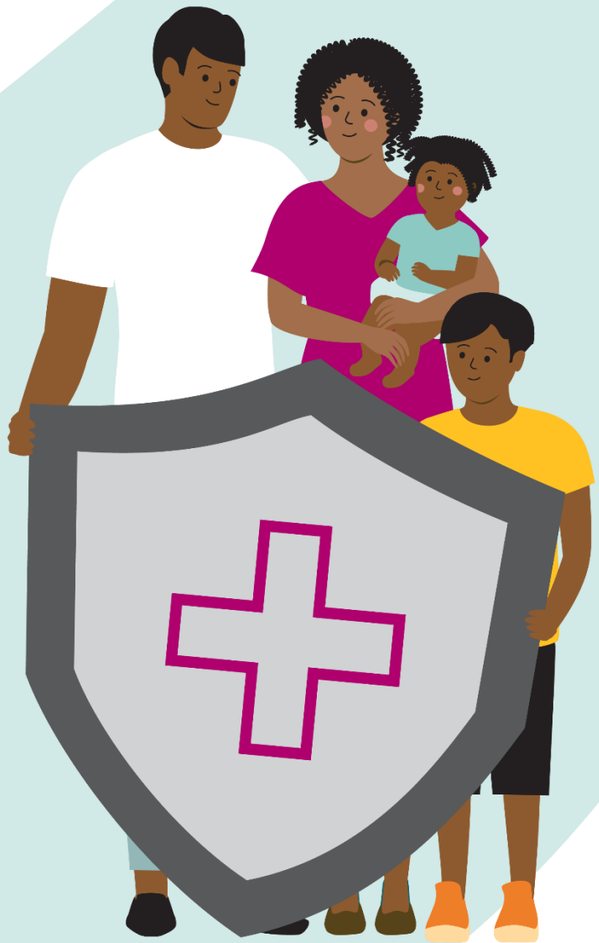

Prior authorizations

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/

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Benefit Tracker

Medical search | EOPs | Manuals | Find Care | Help

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:

Date of birth:

Subscriber ID:

Insurance Type:

Group number:

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

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Prior authorization

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

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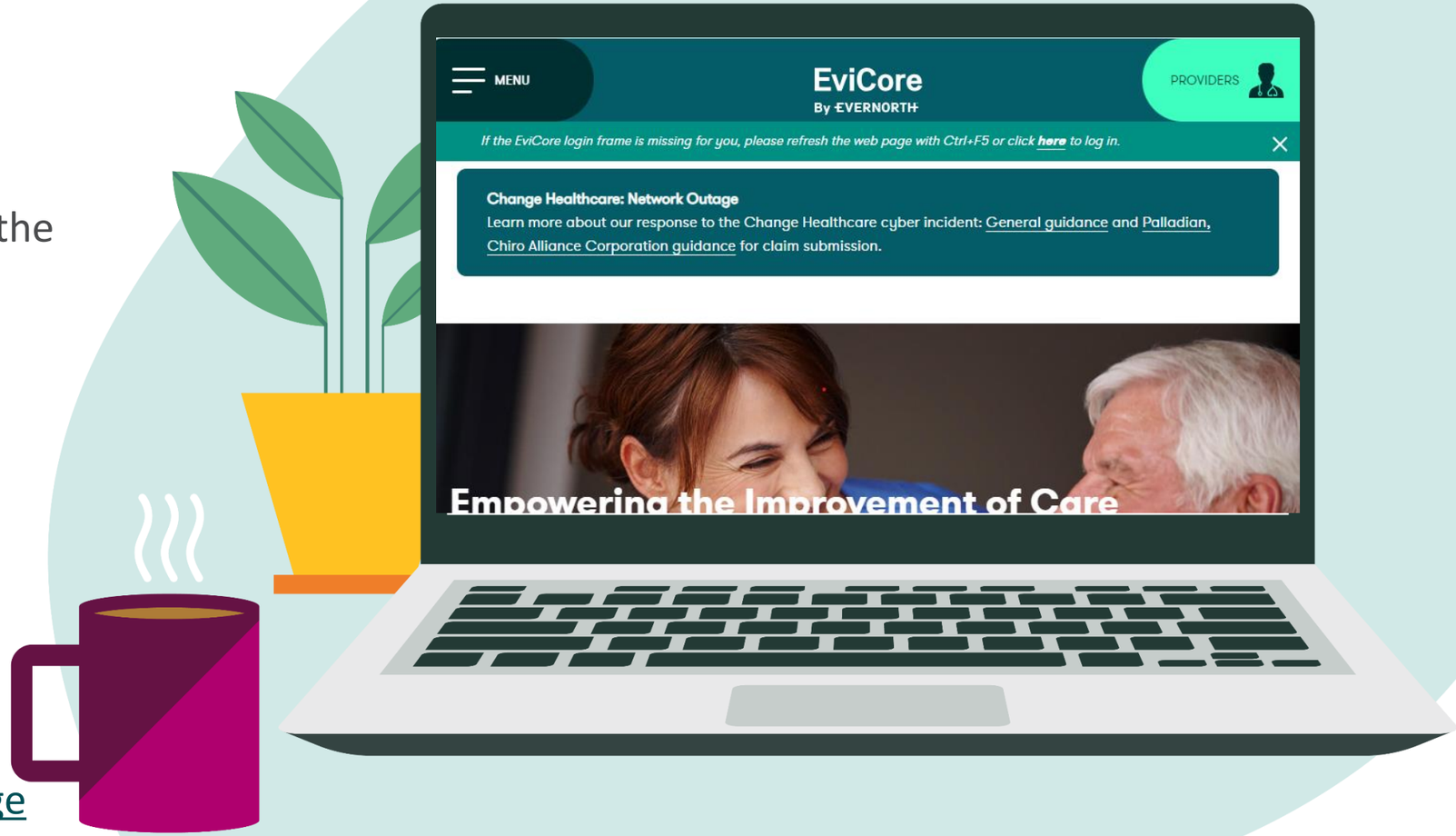
Prior authorizations

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



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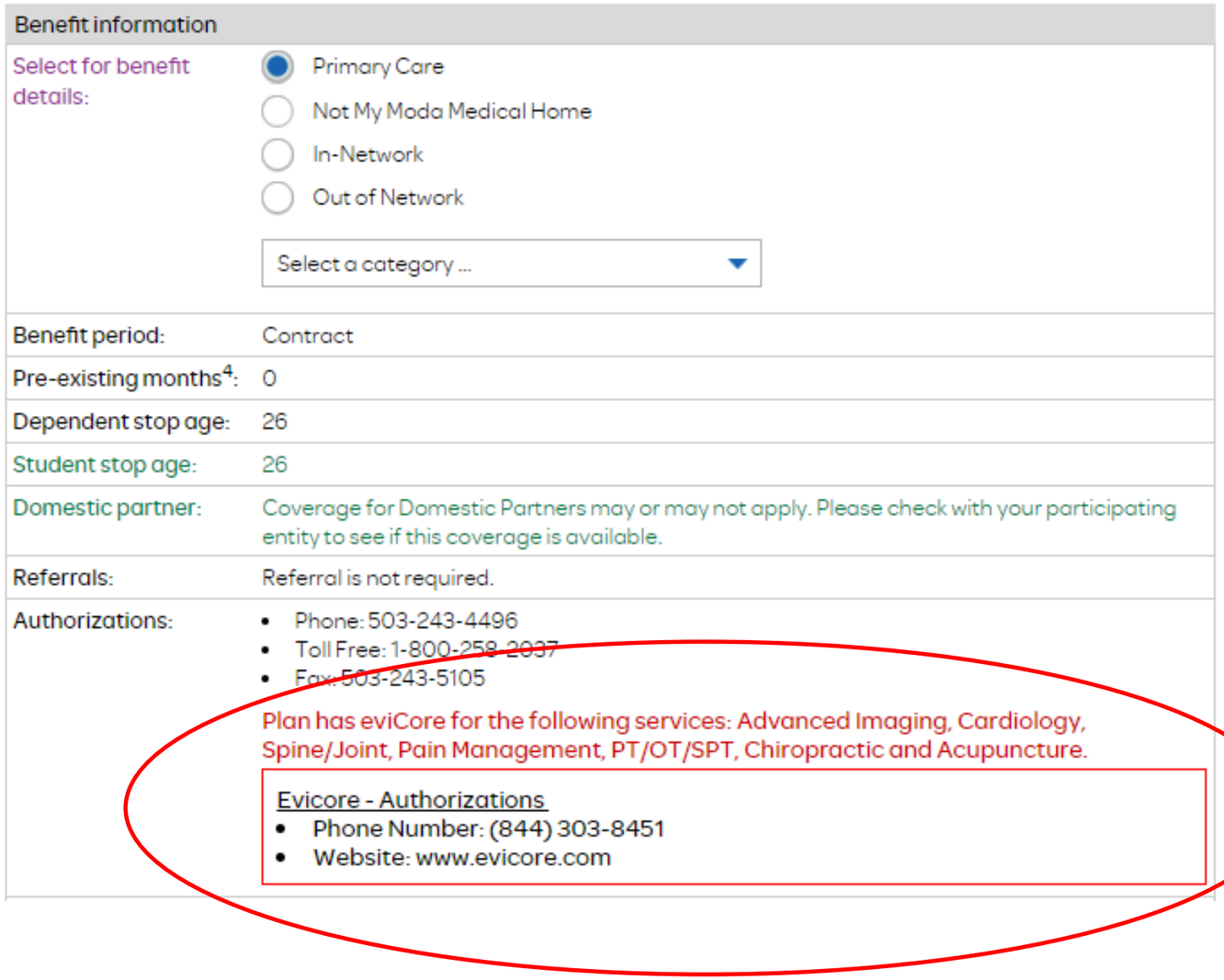
Prior authorizations

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)



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Clinical guidelines

Provider's Hub

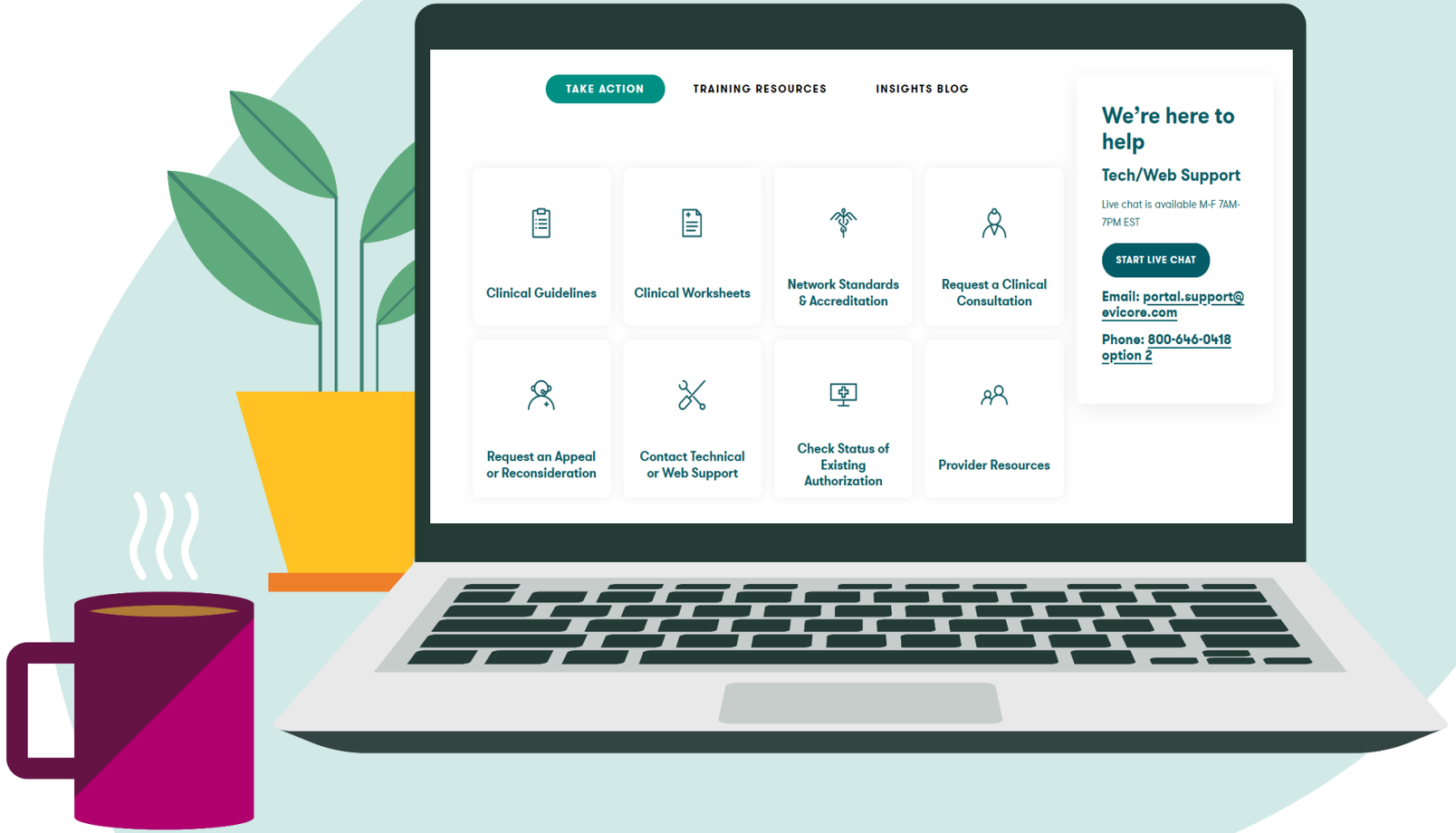
Clinical guidelines/worksheets can be accessed before logging in to the portal.

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 Healthcare (webex.com).

Questions? Email clientservices@evicore.com



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Clinical guidelines

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

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EviCore Newsletter

The newsletter can be helpful in providing the following updates:

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

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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

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Prior authorizations

Provider-administered injectable drug program

Prior authorization required for specific injectable specialty medications.
modahealth.com/medical/injectables/

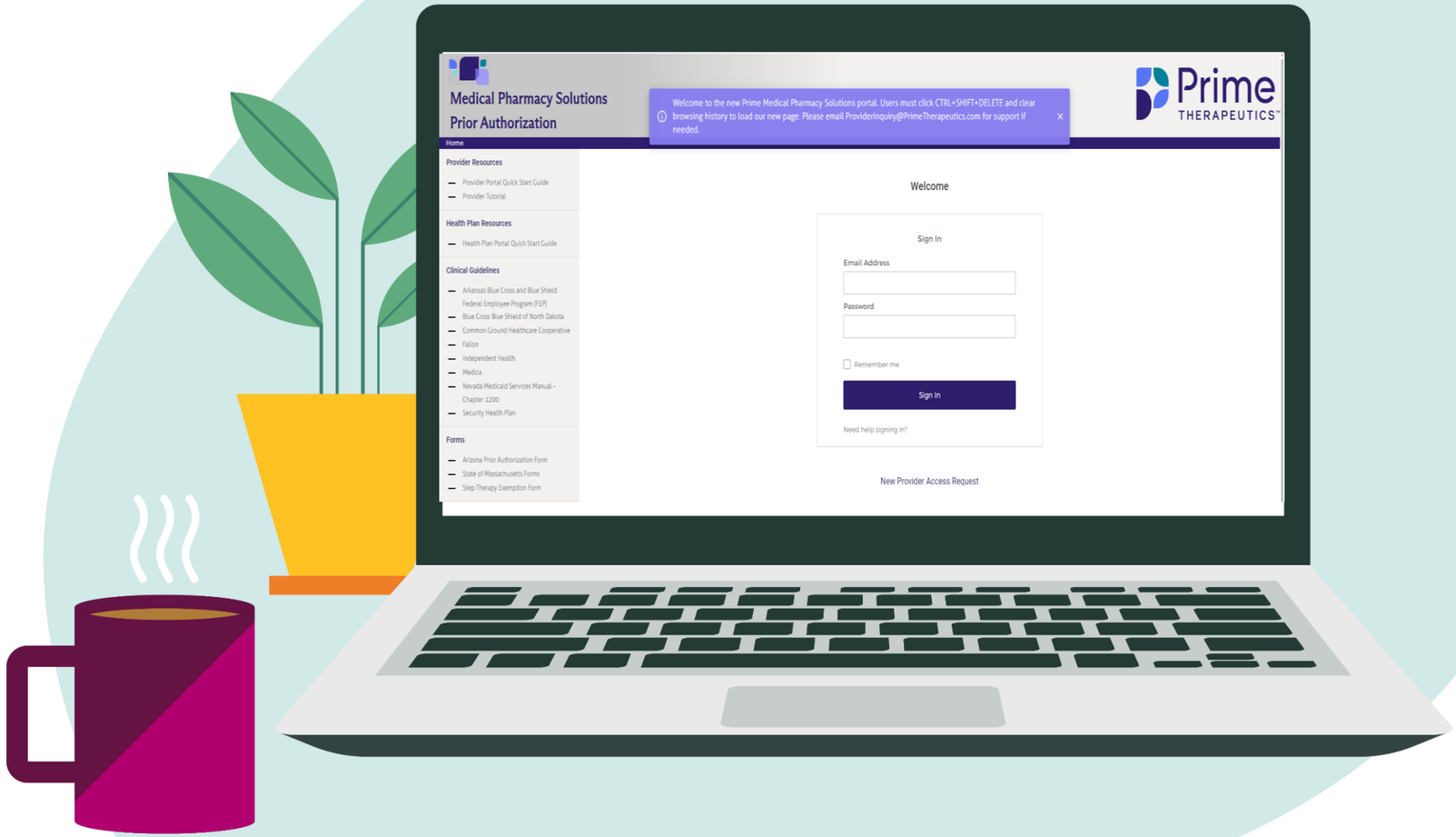
Site of Care program

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)

ProviderInquiry@PrimeTherapeutics.com



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covermymeds®

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

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Appeals

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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

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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

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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

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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

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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.

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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.

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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

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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.

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Healthcare Services

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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

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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

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HEDIS & Quality Measures

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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)

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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*

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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

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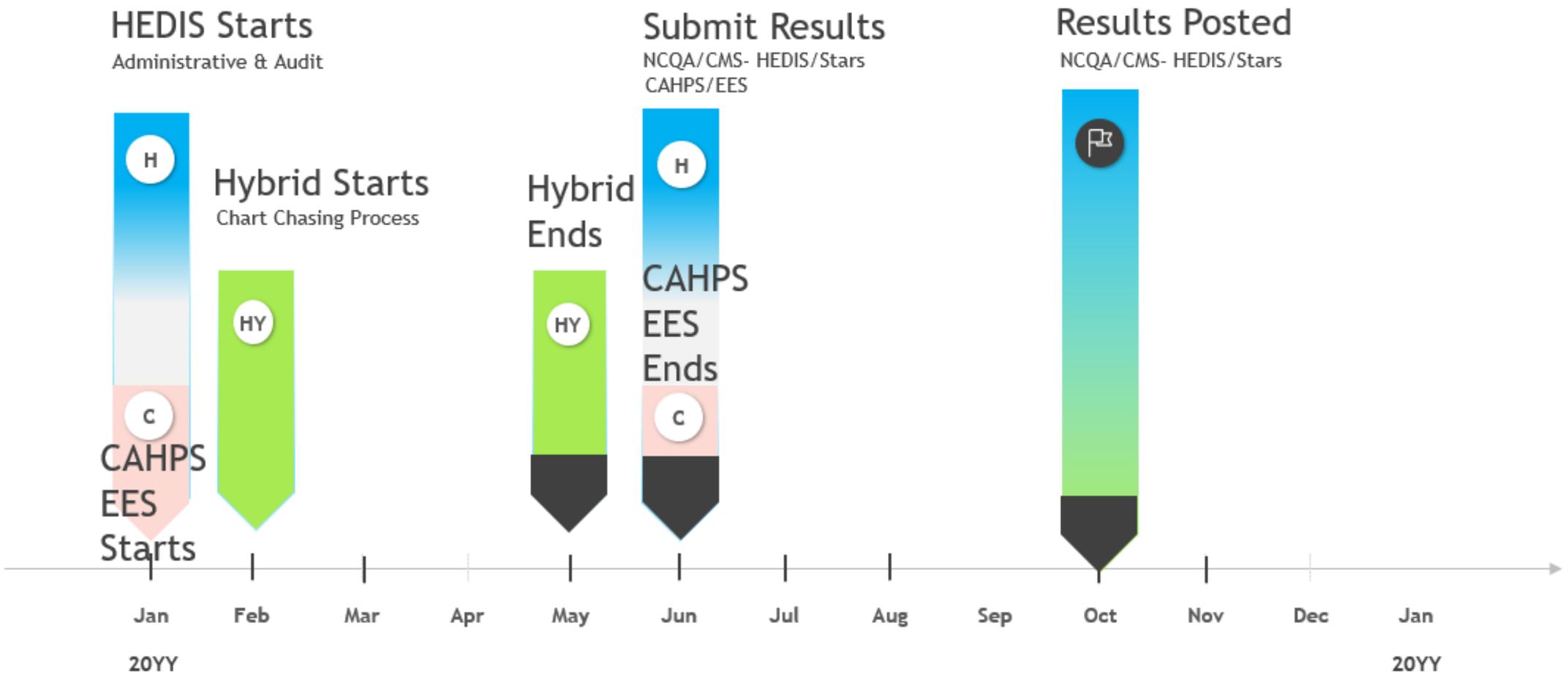
HEDIS timeline



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Provider resources

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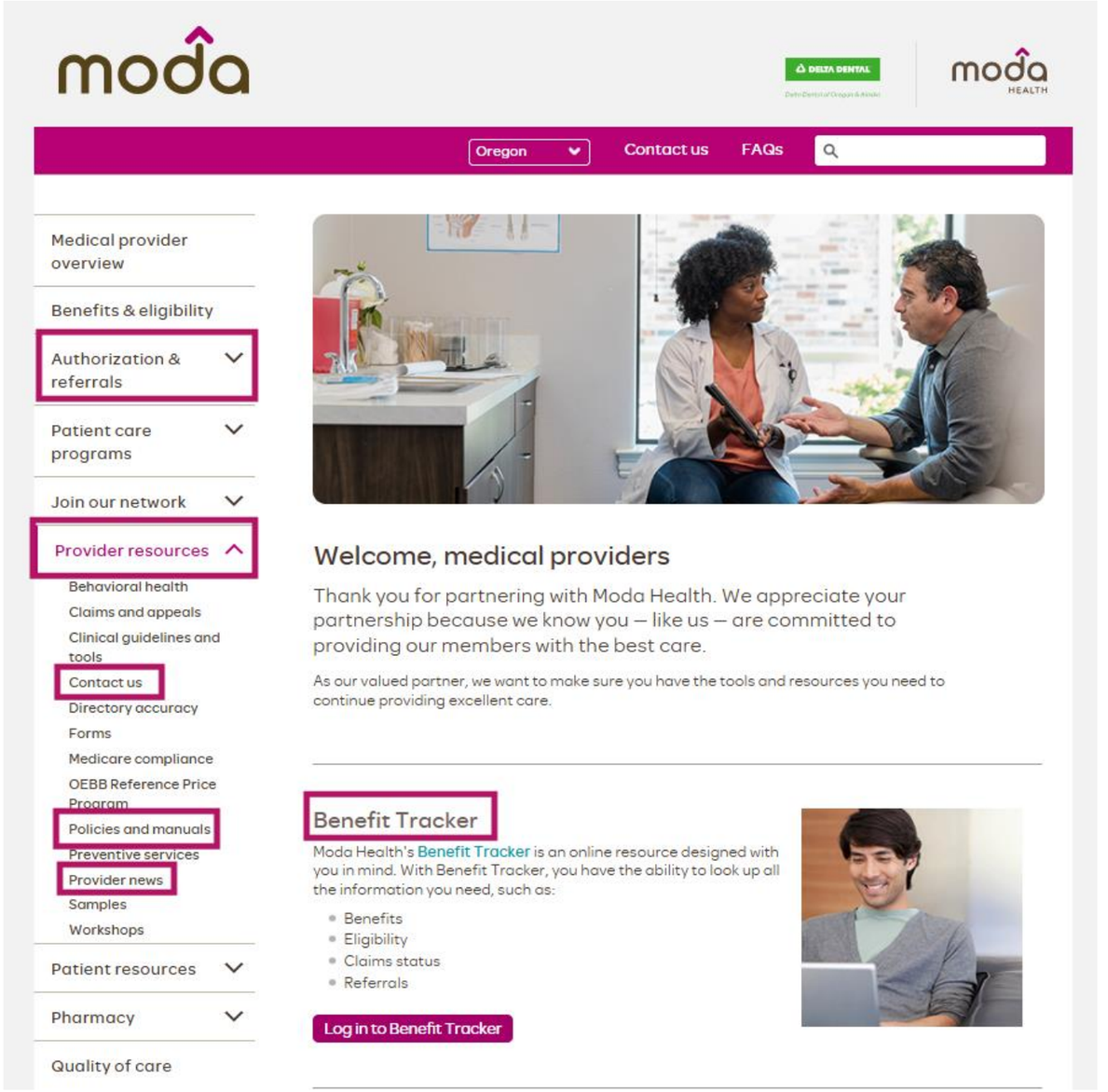
Welcome Moda Health page

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

[ModaHealth.com | Medical Providers: Welcome]

[Medical provider contact us page]



moda HEALTH

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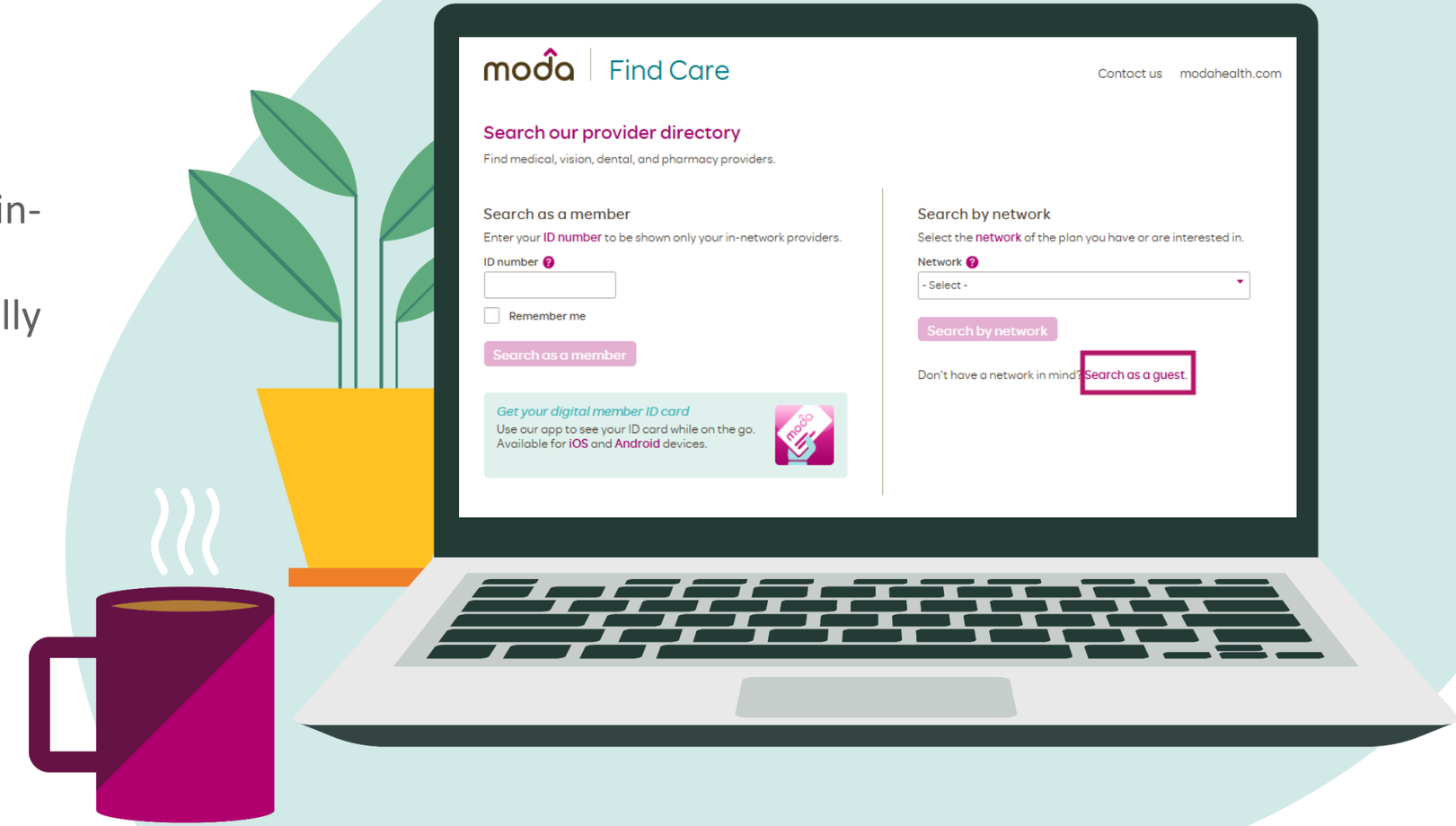
Find Care directory

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]



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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

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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

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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)

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Thank you

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