Medicare Advantage
Participating Provider Manual

Contents

Introduction

Moda Health Plan Inc. administers two separate Medicare Advantage contracts:

- **Moda Health Medicare Advantage** plans are only offered in Western Oregon with a robust provider network throughout the state.
- **Summit Health Medicare Advantage** plans are only offered in the following 12 counties in Eastern Oregon: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler.

There are going to be differences in policies between Moda Health Medicare Advantage, Summit Health Medicare Advantage, and other product lines administered by Moda Health Plan, Inc. Below is a summary of similarities and differences between three products.

	Moda Health Medicare Advantage	**Summit Health Medicare Advantage**	**Eastern Oregon Coordinated Care Organization (EOCCO)**
Plan type	PPO	HMO, HMO-POS	Medicaid Coordinated Care Organization
Membership	Medicare Advantage		Medicaid
Regulated by	Federal government and CMS		State and OHA
Service area	Western Oregon	Eastern Oregon	Eastern Oregon
Network	Statewide		Eastern Oregon
Value based contracting and supporting tools	• Medicare Advantage Primary Care Incentive Program (MAPCIP)	• Medicare Advantage Primary Care Incentive Program (MAPCIP) • Patient Centered Primary Care Home (PCPCH) • Arcadia population health management tool	• Coordinated Care Organization Incentive Model • Arcadia population health management tool

Summit Health is an affiliate of Moda's family of healthcare companies, in partnership with several healthcare providers and health systems across Eastern Oregon.

This Participating Provider Manual is intended to give participating providers helpful and reliable information and guidelines regarding Moda Health and its affiliate, Summit Health's policies, procedures and benefits available to our members.

Throughout this document, we use the term "provider," which refers to licensed health care professionals, clinics and other facilities that contract directly with us as a participating provider. Updates to this manual will be posted to the Moda and Summit Health websites or communicated to you via newsletter. See the 'Contact List' page for more resources.

Where permitted by law, this manual supplements the terms of the Medicare Advantage participating provider agreement you entered into with Moda Health. If any provision of this manual is contrary to applicable laws, the terms of such laws shall prevail.

Take a moment to look over the sections that relate to your responsibilities. You may find the definitions helpful in becoming familiar with common health coverage terminology and, of course, your comments, questions and/or suggestions are always welcome.

Thank you for becoming a team member in the partnership between Moda Health, our employer groups and members, and our participating physicians and providers.

Moda Health contact list

We're here to support you

Our team of experts is available to help you with any questions you may have regarding health plans, patient eligibility or Moda Health programs.

Medicare Medical Customer Service Email: medicalmedicare@modahealth.com Local: 503-265-4762 Toll-free: 877-299-9062 Fax: 503-948-5577	**Medicare Pharmacy Customer Service** Email: pharmacymedicare@modahealth.com Toll-free: 888-786-7509 Fax: 800-207-8235
Behavioral Health Email: behavioralhealth@modahealth.com Local: 503-382-5315 Toll free: 800-799-9391 Authorizations: 855-294-1665 Fax: 503-670-8349	**Provider Credentialing** Email: credentialing@modahealth.com Toll-free: 855-801-2993 Fax: 503-265-5707
Referrals/Authorizations Toll-free: 800-592-8283 Fax: 855-637-2666	**Healthcare Services: Case Management and Disease Management** Local: 503-948-5561 Toll-free: 800-592-8283 Fax: 503-243-5105 Email: casemgmtrefer@modahealth.com
Compliance Issues delegatecompliance@modahealth.com Toll-Free: 855-801-2991	**Electronic Data Interchange Email** Email: edigroup@modahealth.com Local: 503-243-4492 Toll-free: 800-852-5195
Fraud, Waste and Abuse Email: stopfraud@modahealth.com Toll-free: 855-801-2991	**Benefit Tracker** Email: ebt@modahealth.com Local: 503-265-5616 Toll-Free: 877-277-7270
Provider Contract Renewals Email: Contractrenewal@modahealth.com	**Provider Nominations** Email: Providernominations@modahealth.com
HEDIS Support Email: HEDIS@modahealth.com Moda Provider Website: modahealth.com/medical/ Moda Provider Forms: modahealth.com/medical/forms	**Provider Relations and Contracting** Email: providerrelations@modahealth.com

Summit Health contact list

We're here to support you

Our team of experts is available to help you with any questions you may have regarding health plans, patient eligibility or Summit Health programs.

Medical Customer Service Email: medicalmedicare@yoursummithealth.com Toll-free: 844-827-2355 Fax: 855-466-7208	**Pharmacy Customer Service** Email: pharmacymedicare@yoursummithealth.com Toll-free: 844-827-2355 Fax: 855-637-2666
Behavioral Health Email: behavioralhealth@yoursummithealth.com Local: 503-382-5315 Toll free: 800-799-9391 Authorizations: 833-460-0445 Fax: 503-670-8349	**Healthcare Services: Case Management and Disease Management** Toll-free: 833-460-0444 Fax: 503-243-5105 Email: casemgmtrefer@yoursummithealth.com
Referrals/Authorizations Toll-free: 844-931-1778 Fax: 855-637-2666	**Electronic Data Interchange Email** Email: edigroup@modahealth.com Toll-free: 800-852-5195
Compliance Issues delegatecompliance@yoursummithealth.com Toll-Free: 855-801-2991	**Benefit Tracker** Email: ebt@modahealth.com Local: 503-265-5616 Toll-Free: 877-277-7270
Fraud, Waste and Abuse Email: stopfraud@yoursummithealth.com Toll-free: 855-801-2991	**HEDIS Support** Email: EOCCOmetrics@modahealth.com
Provider Relations Email: providerrelations@yoursummithealth.com	**Summit Provider Website**: yoursummithealth.com/provider
Quality Improvement Email: HEDIS@modahealth.com	**Summit Provider Forms**: yoursummithealth.com/provider/resources/forms-docs

Compliance

We value our partners who help us serve our members and share our commitment to excellence in service, performance, and compliance. Both Moda Health and Summit Health maintain a compliance web page. The Moda page is found at Moda Health Medicare Compliance Plan and the Summit page is Summit Health | Providers - Medicare compliance . Each page provides information on topics such as code of conduct, noncompliance reporting, and a compliance plan.

Compliance program guidelines

[42 CFR §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)]

CMS publishes Medicare compliance program requirements in the Medicare Managed Care Manual (MMCM), Chapter 21, and the Prescription Drug Benefit Manual (PDBM), Chapter 9. The Medicare compliance program requirements apply equally to plan sponsors, (Moda Health and Summit Health), and any individual/entity , Moda Health and Summit Health contract with for services related to the Medicare Advantage (Part C) and Prescription Drug (Part D) program. These individuals/entities are classified a first tier, downstream and/or related entity (FDR). Moda Health and its affiliate, Summit Health refer to these entities as "Delegates". Definitions for First Tier, Downstream, and Related Entities are found in the CMS manuals, accessed using the following link: CMS Manuals Chapter 9 and 21

Compliance program, compliance policies, compliance information and code of conduct

[42 CFR §§ 422.503(b)(4)(vi)(A), 423.504(b)(4)(vi)(A)]

All Delegates that support the Medicare Advantage (Part C) and/or Prescription Drug (Part D) program on behalf of Moda Health and its affiliate, Summit Health must either abide by the Moda Health or Summit Health Code of Conduct and policies and procedures or adopt an internal code of conduct (code) and policies and procedures consistent with the CMS requirements outlined in Section 50.1.1 of the Medicare Managed Care Manual (MMCM), chapter 21, and the Prescription Drug Benefit Manual (PDBM), chapter 9.

A code states over-arching principles and values by which an individual and/or organization operates and defines the underlying framework for compliance policies and procedures. The code must provide the standards by which an individual and/or organization must conduct itself, including the responsibility to perform duties in an ethical manner and in compliance with laws, regulations, and policies and procedures whether or not specifically addressed in the code. The code, or supplemental policies and procedures, should include provisions to ensure those responsible for the administration of Medicare benefits are free from conflicts of interest. Conflicts of interest are created when an activity or relationship renders a person unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity or provides a person with an unfair competitive or monetary advantage.

Additionally, the code or supplemental policies and procedures must include provisions requiring employees (temporary, part-time, full-time, and volunteers) and contractors to report issues of non-compliance and potential fraud, waste, and abuse (FWA) through designated mechanisms. The code and supplemental policies and procedures must be reviewed annually and made available to all employees (temporary, part-time, full-time, and volunteers) and contractors. Delegates should ensure that all employees (temporary, part-time, full-time, and volunteers) and contractors agree to abide by the code and keep record of these acknowledgements.

Please distribute or make available to your employees Moda Health's or Summit Health's Code of Conduct if your Code of Conduct is not comparable to ours.

Reporting mechanisms and disciplinary standards

[42 CFR §§ 422.503(b)(4)(vi)(D), 423.504(b)(4)(vi)(D)]

[42 CFR §§, 422.503(b)(4)(vi)(E) (1-3), 423.504(b)(4)(vi)(E) (1-3)]

A Delegate and its employees (temporary, part-time, full-time and/or volunteer), contractors and/or subcontractors who conduct work with Medicare beneficiaries on behalf of Moda Health or its affiliate, Summit Health must provide notice throughout its facilities of the duty to report any observed or suspected noncompliance or potential fraud, waste, or abuse (FWA). The notice must provide mechanisms to report any observed or suspected noncompliance and/or potential FWA and should include a 24-hour, anonymous reporting option. The Delegate may utilize an independent third-party to provide an anonymous reporting option for employees. Notices should include

reference to the Delegate's non-intimidation and non-retaliation policy for employees, contractors and/or subcontractors who report compliance and/or FWA concerns in good faith.

If the Delegate does not have reporting mechanisms consistent with CMS requirements, the Delegate should provide Moda Health or Summit Health's reporting mechanisms, including the following:

- Moda Health compliance department emails (delegatecompliance@modahealth.com, medicarecompliance@modahealth.com, stopfraud@modahealth.com);
- Summit Health compliance department emails (delegatecompliance@yoursummithealth.com, medicarecompliance@yoursummithealth.com, stopfraud@yoursummithealth.com)
- Compliance department phone number (855-801-2991).
- EthicsPoint, a confidential third-party hotline (866-294-5591) and website (www.ethicspoint.com).

OIG and GSA screening

[42 CFR § 1001.1901]

A Delegate and its employees (temporary, part-time, full-time and/or volunteer), contractors and/or subcontractors who provide administrative and/or healthcare support to Medicare beneficiaries on behalf of Moda Health and its affiliate, Summit Health are prohibited from employing or contracting with persons or entities that have been excluded from doing business with the federal government. Upon hiring or contracting and monthly thereafter, Delegates are required to verify that their employees (including temporary employees, contractors, and volunteers) are not excluded by comparing them against the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), and the General Services Administration (GSA) and Excluded Parties List System (EPLS).

No payment will be made by Moda Health, Summit Health, Medicare, Medicaid or any other federal or state health care programs for any item or service furnished on or after the effective date specified in the notice period, by an excluded individual or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.

To assist you with implementation of your OIG/GSA exclusion process, links to the OIG and GSA exclusion websites and descriptions of the lists are below.

Excluded Party List System (EPLS) – www.sam.gov

This list is maintained by the General Services Administration (GSA), now a part of the System for Awards Management (SAM). The EPLS is an electronic, Web-based system that identifies those parties excluded from receiving federal contracts, certain subcontracts and certain types of federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government and individuals barred from entering the United States.

List of Excluded Individuals and Entities (LEIE) – exclusions.oig.hhs.gov

This list is maintained by the Office of Inspector General (OIG) and provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.

Sub-delegation

Sub-delegation occurs when a Delegate contracts with a third party to carry out a responsibility Moda Health and its affiliate, Summit Health had contracted with the Delegate to perform. In the event the Delegate sub-delegates any delegated function, the Delegate must obtain advance written approval from Moda Health, its affiliates. The contract between Moda Health, its affiliate Summit Health and the Delegate will be amended to include the sub-delegation. Any updated agreements shall be filed with the appropriate governmental agencies. Any sub-delegation shall be subject to all requirements set forth herein as mandated by CMS.

Offshore Subcontractors

The term "offshore" refers to any country that is not the United States or one of the United States territories (i.e., American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands).

Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside of the United States or foreign-owned companies with their operations performed outside of the United States. Offshore subcontractors provide services that are performed by workers located in a country that is not the United States or its territories, regardless of whether the workers are employees of American or foreign companies.

The Delegate must ensure its employees have read and understand all requirements pertaining to the regulations for services that are performed by workers located offshore, regardless of whether the workers are employees of American or foreign companies. Consistent with CMS direction, this applies to entities the Delegate may contract or sub-contract with to receive, process, transfer, handle, store, or access beneficiary protected health information (PHI) in oral, written, or electronic form. In the event the Delegate sub-delegates any Moda Health or Summit Health Medicare activities to an offshore subcontractor, the Delegate will be required to adhere to the approval process outlined for sub-delegation activities and complete a separate offshore attestation.

Additional resources

For more information on laws governing the Medicare program or for additional healthcare compliance resources, please see:

- Title XVIII of the Social Security Act
- Medicare regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
- Anti-kickback statute (42 U.S.C. § 1320a-7b(b))
- Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
- OIG Compliance Program guidance for the healthcare Industry: OIG Compliance Guidance

Medical Contracting and Provider Relations

What types of provider contracts are currently offered?

Moda Health and its Affiliates, including Summit Health, offer a variety of contracts in Oregon. If you have questions about your current contract, or to find out which networks you are participating in, please contact your Provider Relations representative. If you are a new provider without an established relationship with Moda Health and you would like more information on how to become contracted, please contact providernominations@modahealth.com.

Contracting requirements

Contracted providers are prohibited under 42 CFR 422.752 (a)(8) from employing or contracting with first tier and downstream entities, physicians or providers who have been excluded from participation in Medicare under section 1128 or 1128A of the SSA

All payment and incentive arrangements specified between Moda Health, Summit Health, and contracted providers, first-tier and downstream entities will be specified in all Medicare Advantage participating provider agreements.

We will notify contracted providers in writing the reason for all denials, suspensions, or terminations.

For contract termination without cause, Moda Health, its Affiliates, or the Participating Provider must provide a minimum of ninety (90) days prior written notice to the other party specifying a termination effective date, and that termination is being made under the provisions of the contract. Moda Health and all contracted providers will cooperate in full with CMS when submitting encounter data, medical records and to certify completeness and truthfulness of all material submitted.

Either Moda Health, its Affiliates or the Participating Provider may terminate a Medicare Advantage contract by providing at least 60 days prior written notice to the other party, specifying the cause for the termination and providing the other party with appeal rights and timelines. Contract termination with cause includes any material violation of the contract.

If a Provider loses their license, opts out of Medicare or is assessed CMS sanctions, the Providers participation in the Medicare Advantage network will terminate immediately.

Active participation requires the approval of credentialing and implementation of the contract.

We will contract directly with the provider, contingent on panel openings and availability. To contract with us, MDs and DOs must have privileges at a participating hospital or the plan for continuity of care for patients who require admitting

What are the steps involved in credentialing?

The first step is to submit a completed Oregon practitioner credentialing application approved by the ACPCI. If you need a copy of the Oregon credentialing or re-credentialing application, you can access an electronic copy from the Oregon Health Authority Policy and Research website at www.oregon.gov/oha/OHPR/ACPCI/pages/state_app.aspx.

- Our credentialing staff will process the application by verifying the information and will contact your office if additional information is needed.
- Once the verification is complete, the credentialing supervisor reviews the application for any concerns. If necessary, the concerns are also reviewed by our medical director and/or the credentialing committee, and a decision for participation is made.
- A letter is sent to the provider within 60 days of the credential out-of-network service authorization requests committee meeting to notify the provider of the decision.

Provider Configuration Email: Providerupdates@modahealth.com Fax: 503-243-3964 Contact Medical Provider Configuration for: • New provider information • Adding or deleting a provider • Adding Provider NPI • Updating provider phone number • Updating provider address • Updating provider TIN number (W-9 required) • All other demographic updates	**Provider Relations Representative** Email: Providerrelations@modahealth.com or providerrelations@yoursummithealth.com Fax: 503-243-3964 Contact Provider Relations for: • Escalated or trending claims issues • Medical provider workshop information • Provider education materials • Reimbursement policy manual (found here) • Medical necessity criteria updates (found here)
New Provider Nominations Email: Providernominations@modahealth.com Contact Provider Nominations for: Initiating a new contract	**Medical Provider Contract Renewal** Email: Contractrenewal@modahealth.com Contact Contract Renewal for: Contract renegotiations

Credentialing and recredentialing

We perform credentialing and recredentialing activities that entail but are not limited to credentials verification, review and monitoring of past and present malpractice claims, state licensing disciplinary activity, adverse outcomes, medical recordkeeping, office site, member access to providers and surveys. Providers must complete the credentialing process and approval prior to treating our members.

Participating on our provider panel:

Participation criteria:

Providers must meet the following criteria, applicable to their degree and specialty, to participate on our provider panel. We have the right to deny participation based on, but not limited to, these criteria.

- Completion of undergraduate, graduate, medical and/or dental school
- Ability to prescribe medication or have a documented prescription writing process with another Moda Health participating provider
- Ability to admit patients to a Moda Health contracted hospital independently or have a documented hospital admitting process with another Moda Health participating provider
- Adequate professional malpractice insurance coverage of a minimum of $1,000,000 per claim and $3,000,000 annual aggregate for all professional practitioners (please refer to the Moda Health provider classification table)
- Adequate general malpractice insurance in an amount not less than $1,000,000 per claim and
- $3,000,000 annual aggregate. If the provider is an ambulatory surgery center or hospital, the provider shall maintain general liability insurance in an amount not less than $2,000,000 per claim and $5,000,000 aggregate.
- Current, active state license(s) for all practicing locations
- Primary care providers are required to provide coverage 24 hours a day, 7 days a week
- Ability to practice within their scope of practice, as defined by law and appropriate state licensing boards
- Never proven guilty of a federal crime within a court of law
- Not excluded or sanctioned by the federal government
- National Provider Identifier, type 1-Individual

Who requires credentialing?

Refer to the provider classification table set forth herein. Locum tenens of 91 or more calendar days of service who are new to the panel are required to complete a credentialing application. If already credentialed by Moda Health, they submit the documents listed below.

- If 90 calendar days or less of service, and locum credentialing has not been completed within a look back year, a provider is not required to complete a full application but must submit a letter including:
- Full name
- Other names used
- Date of birth
- Social Security number
- Date range of coverage
- Name of practitioner requiring coverage, or reason for coverage
- Practice and billing information
- Copies of state licensure, malpractice insurance coverage, DEA certificate (if applicable) and completed attestation attached to the initial application
- Name of medical school, degree received and year of graduation.
- Completed and signed OPCA attestation and authorization to release information pages

Primary Care Providers (PCP) status:

A primary care provider is licensed as an MD, DO, NP, PA, or ND (see Provider Classification table for requirements) and specializes in family medicine, internal medicine, obstetrics/gynecology, pediatrics, adolescent medicine, women's health, general practice, midwifery (NP degree required) or geriatrics. A PCP can provide services within their scope of practice as defined by law and state licensure, have hospital admitting privileges or arrangements, and the authority to prescribe medication. A PCP is required to participate in medical record audits, an office site visit, and access and after-hours surveys. For more information see Medical Records, Office Site, Access and After-Hours Standards, and Audits.

Application required:

Credentialing

- A provider new to the Moda Health panel
- A returning provider whose contract was terminated, and a new contract is not put in place within 30 days
- Locum tenens providing services for 90 calendar days or longer

Recredentialing

- An established provider completes one within three (3) years from the last application approval date. This is required to continue participating on our panel. We will remind the provider by mailing the application to the provider.
- An established provider who has returned from a leave of absence and is requesting within three years to be reinstated
- A provider who was on our panel through a delegated entity and is requesting direct participation on the panel

Application forms accepted:

- The current Advisory Committee on Physician Credentialing Information (ACPCI)-approved Oregon Practitioner Credentialing Application (OPCA) or Recredentialing Application (OPRA) for providers practicing in Oregon and/or any other state
- The Washington Provider Credentialing or Recredentialing Application if the provider's primary practice is in Washington
- Organizational Provider Credentialing Application (for facility credentialing)

We do not accept, and will return, applications that:

- Are incomplete or unsigned
- Combine credentialing or recredentialing applications
- Combine state applications
- Have signed attestation statement signatures that are 60 or more days old

Helpful hint:

An electronic Microsoft Word or PDF version of the OPCA and OPRA can be downloaded from the Oregon Health Plan Policy and Research website at: www.oregon.gov/oha/OHPR/ACPCI/pages/state_app.aspx

The Application and Attestation

The provider is responsible for the accuracy of the information on the application and for signing and dating the application, the attestation, and the authorization to release form. The application should be completed in accordance with the instructions on page one. Legible copies of the following applicable, current, and valid documents must be attached to the application. We do not accept documents that have been altered.

These include:

- Federal Drug Enforcement Agency (DEA) certificate or a clinic DEA certificate
- All active state professional license(s).
- Malpractice insurance, carrier face sheet, or a dated letter from the insurance carrier stating the intent to insure. The provider's name, coverage amount, and effective dates must be included.
- Explanation of all affirmative answers on the attestation statement
- Completed "Attachment A" explaining malpractice claims activity
- Education Commission for Foreign Medical Graduates (ECFMG) certificate
- Federally commissioned physician status
- Federal tort claim status

We will contact the provider's office if the required documents are missing, expired, illegible or missing necessary information and will request an acceptable copy or a written explanation if the provider is unable to comply with the request.

The Attestation statement addresses:

- Inability to perform the essential functions of the position due to health status, with or without accommodation
- Past or present abuse of alcohol or prescription and/or illegal drugs
- Any state license, certification, registration to practice, participation in a public program (i.e., Medicare/Medicaid), clinical privileges and/or hospital privileges that have been or arecurrently voluntarily or involuntarily denied, limited, restricted, suspended and/or revoked
- History of misdemeanor or felony criminal activity
- Past and present malpractice activity
- Reporting to a state or federal data bank

Helpful hint:

Keep the original copy of the completed application, not signed, and dated, for future use. A copy of the original can be signed, dated, and submitted to organizations that request copies.

Returning the application:

Medical, behavioral health, alternative care practitioners, and Organizational provider documentation may be returned via fax, email, or regular mail:

Email: Credentialing@modahealth.com

Fax: (503) 265-5707

Moda Health

Attn: Provider Credentialing

8th Floor 601 S.W. 2nd Avenue

Portland, OR 97204

Primary source verification of credential application elements

We verify application elements by performing primary source verification (PSV) through the original entity directly responsible for issuing the credential or a National Committee for Quality Assurance (NCQA) approved alternative source. A query of the National Provider Databank (NPDB) is performed. Education and training are not re-verified at the time of re-credentialing.

Application elements related to the provider that may be subject to verification include the following:

- Current and past state license/s
- DEA certificate
- Malpractice insurance coverage or letter of intent from the malpractice insurance carrier
- Hospital affiliation or receipt of a documented admitting process with other Moda Health participating providers
- Current practice information
- Gaps in work history of two (2) months or more
- Work history
- Medical, dental, or undergraduate education from an accredited school
- Education Commission for Foreign Medical Graduates (ECFMG) certificate
- Postgraduate training (i.e., internship, residency, etc.)
- Board certification
- Malpractice claim history of last five (5) years, three (3) years for re-credentialing
- Medicare/Medicaid sanctions/exclusions
- State license sanctions of last five (5) years, three (3) years for re-credentialing
- Additional administrative data relating to a provider's ability to provide care and service to Moda Health members
- National Provider Identifier, type 1- Individual

Discrepancy in credentialing information

Information obtained during the verification process that varies substantially from the information submitted by the applicant requires a written explanation from the applicant.

- Our team notifies the applicant in writing of the discrepancy and requests a written explanation within seven (7) calendar days. The response is reviewed by the medical director or our credentialing committee.
- If the applicant does not respond within seven (7) calendar days, then the applicant is contacted by telephone requesting a response in writing within 7 calendar days. If no response is received, the application process is terminated, and the applicant is notified via certified letter.

Practice information changes between credentialing cycles

The provider is responsible for providing accurate and timely notification of practice information changes. Notification of changes in practice location, credentialing contact information, including phone, fax numbers, and email address, must be received within 30 days of the change, failure to send notification may result in expiration and/or termination of the credentialing status.

Application approval or denial

Our medical director or credentialing committee will review the application information and decide to:

- Approve the application.
- Approve the application for a conditional time frame. The provider is monitored for the conditions stipulated in the approval.
- Pend the application and request additional information to be reviewed at a future credentialing committee meeting. The applicant is monitored as a pending applicant.
- Deny the application completely. Only the credentialing committee is authorized to make this decision.

We will notify the provider or appropriate credentialing contact person in writing within sixty (60) calendar days of the medical director's or credentialing committee's decision.

Provider Rights:

Providers have the right to:

- Not be discriminated against based on the provider's race, ethnic/national identity, gender, age, sexual orientation, or types of procedures performed, legal under U.S. law, or patients in whom the provider specializes.
- Review information obtained by Moda Health and its affiliates, to evaluate the credentialing application. Information that is peer-protected and protected by law is not shared with the provider.
- Correct erroneous information discovered during the verification process.
- Request, from the credentialing supervisor, the credentialing application status via telephone, email, or correspondence.
- Withdraw the application, in writing, at any time.
- Have the confidentiality of the application and supporting documents protected, and the information used for the sole purpose of application verification, peer review and panel participation decisions.
- Be notified of these rights.

Provider appeal of adverse action

Providers or practitioners have the right to appeal a decision to take adverse action against the provider's or practitioner's participation status. The provider or practitioner is notified of their appeal rights through various Moda Health sources. We reserve the right to decide if the appeal follows our standards. The appeal process is compliant with the Healthcare Quality Improvement Act (HCQIA) of 1986.

> *The provider or practitioner has up to 60 calendar days following the receipt of the medical director's letter of decision to take an adverse action to file a written request for hearing with the credentialing committee. The written request is mailed to the medical director by certified mail. A provider or practitioner who fails to request a hearing within the time and in the manner specified waives any right for a hearing in the future.*

Confidentiality

All credentialing-related information is considered strictly confidential. No disclosure of peer review information in accordance with ORS 41.675 will be made, except to those authorized to receive such information to conduct credentialing activities. The data utilized by the credentialing committee is strictly confidential and is only available to authorized personnel in accordance with local, state, federal and other regulatory agencies' statutes, rules, and regulations.

Health provider classification table

Practitioner classification	Degree/Title	Specialty	Contract credential comments
Medical Physicians	**DC** - Doctor of Chiropractic Medicine **DO** - Doctor of Osteopathic Medicine **DPM** - Doctor of Podiatric Medicine **MD** - Doctor of Medicine **ND** - Doctor of Naturopathic Medicine **OD** - Doctor of Optometry	All specialties Psychiatry Radiologist, pathologist, or anesthesiologist who are providing services to independent physicians who are practicing in an outpatient setting	Contract – Yes Credential – Yes Not applicable – Physicians who are not contracted directly with Moda Health through an individual, clinic, medical group and/or independent physician association Physicians accessed through a delegated third-party panel Providers practicing in an inpatient setting. *(See below)* Doctor of Naturopathic Medicine must: • Work with a member's PCP to provide care • Completed 3-year Residency at an accredited program • Have a DEA or prescribe plan • Hospital Admitting privileges or an admit plan • 24/7 call coverage • If the criteria above are not met, the provider must be listed as a specialist.

Practitioner classification	Degree/Title	Specialty	Contract credential comments
Allied Health Professionals	Alternative Medicine LAc - Licensed Acupuncturist CNM - Certified Nurse Midwife (CNM, NP and RN licensed) NP - Nurse Practitioner CRNA - Certified Registered Nurse Anesthetist PA - Physician Assistant PT/OT - Physical or Occupational Therapist LMP - Licensed Massage Practitioner RD - Registered Dietician MA/MS - Speech & Language Pathology/Audiology, Hearing Aid Specialists Lactation Consultant Mental Health Providers – see below	▪ Naturopath ▪ Homeopath ▪ Acupuncture Midwifery: ▪ Certified Nurse Midwife (with active NP and RN license) ▪ Nurse Midwife Nurse Practitioner ▪ Registered Nurse Speech/Language Pathology, Audiology Hearing Aid Specialists Nurse Practitioner (NP) specialties that can practice as a PCP: ▪ ACNP - Acute Care ▪ ANP - Adult ▪ FNP - Family ▪ GNP – Geriatric ▪ NMNP – Nurse Midwife ▪ NNP - Neonatal ▪ PNP - Pediatric ▪ WHCNP - Women's Health Care CRNA – Certified Registered Nurse Anesthetist, outpatient practice only Therapist specialties: ▪ Occupational ▪ Physical ▪ Massage (7/1/2014) RD – Registered Dietician (7/1/2014)	Contract - Yes Credential – Yes

Mental Health Practitioners	LCSW - Licensed Clinical Social Worker PhD - Doctor of Philosophy PsyD - Doctor of Psychology LMFT - Licensed Marital and Family Therapist LPC - Licensed Counselor PMHNP - Mental Health Nurse EdD - Doctor of Education MA/MS - Psychology Associate (non-supervised) BCBA – Board Certified Behavioral Analyst BCBAD - Board Certified Behavioral Analyst, Doctoral level BCaBA – Board Certified Assistant Behavioral Health Analyst	Alcohol and Drug Abuse Counselor Clinical Psychologist License Independent Clinical Social Worker Mental and Behavioral Health Counselor	Contract – Yes Credential – Yes Physicians who are certified in addiction medicine Doctoral- and master's-level psychologists who are state licensed or state certified Licensed or certified master's-level clinical social workers Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state-certified or state-licensed Other licensed, certified, or registered behavioral health specialists Credentialing not required for psychology associates practicing under supervision
Dental Physicians Dentist or dental surgeons who provide care under a medical benefit program.	DDS - Doctor of Dental Surgery DMD - Doctor of Medical Dentistry LD - Denturists RDH - Registered Dental Hygienists, Limited Access Permit (LAP)/Extended-Practice Permit required.	Surgery Oral Pathology Oral Maxillofacial Surgery Periodontics Endodontics Orthodontics Pediatric Dentistry Prosthodontics Public Health Dental Hygienists with LAP/Extended-Practice Permit only.	Contract – Yes Credential – Yes

Locum Tenen Please contact credentialing@modahealth.com for more information on credentialing Locum Tenen's.	All degrees	All specialties	Contract – Yes Credential – Yes
Providers not requiring credentialing **Providers practicing in an in-patient setting; see below** **Dentist who provides primary dental care only under a dental plan or rider.**	RN - Registered Nurse RNFA - Registered Nurse First Assist	Other: ▪ Anesthesiologist Assistant ▪ Biofeedback ▪ Cardiovascular (Clinical) Perfusionist ▪ Cardiovascular Technologist ▪ Diagnostic Medical Sonographer ▪ Electro-neuro Diagnostic Technologist ▪ Non-physician Surgical Assistant	Contract – Yes Credential – No
In-patient setting only employees or providers **Practitioner who practices exclusively within the inpatient setting (health delivery organizations) and provides care only because of our members being directed to the inpatient setting**	All degrees	Inpatient settings (health delivery organizations) ▪ Employees ▪ Radiologist* ▪ Pathologist* ▪ Anesthesiologist only ▪ Neonatologists ▪ ER physicians ▪ Behavioral Health ▪ Nurse Anesthetist	Contract – Yes Credential – No Contract and credential the hospital or facility – see Credentialing Health Care Delivery Organizations

Practitioner who does not provide care for members in a treatment setting (e.g., board-certified consultants)		* If the radiologist or pathologist is also offering services to independent physicians who are practicing in an out-patient setting, they must be credentialed. See *Medical Physicians* above.	

Plan descriptions/Product summaries

Moda Health Plan, Inc, and its Affiliates, have entered a contract with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Advantage Preferred Provider Organization (PPO) plans and a Prescription Drug Plan (PDP). Summit Health Plan, Inc has contracted with CMS to offer Health Maintenance Organization (HMO) plans.

PPO Plan: A plan that provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the plan's network of providers, however, member cost-sharing amounts may be higher when services are rendered from a non-plan provider. Plan may or may not include Part D prescription drug coverage.

HMO Plan: A plan that requires members to obtain all non-urgent/emergent services from network providers and to obtain referrals from their designated Primary Care Provider (PCP) for certain specialty care that cannot be furnished by their PCP. Plan may or may not include Part D prescription drug coverage.

HMO-POS Plan: A type of HMO plan which offers coverage for certain specified services outside of the plans network or without obtaining a referral from the member's PCP at a high member cost-sharing. Plan may or may not include Part D prescription drug coverage.

PDP Plan: A plan that offers Part D prescription drug coverage only.

CMS pays MAOs, such as Moda to manage and pay for health services for people with Medicare who enroll in one of the Medicare Advantage plans offered by Moda Health Plan, including its affiliate, Summit Health Plan.

All Medicare Advantage plans offered by Moda Health and its affiliate, Summit Health include a network of providers, who are a vital component to ensuring our shared members and patients are well served.

To locate a participating Medicare Advantage provider,

Visit Moda Find Care | (modahealth.com). Select Guest, then Medical, and click the Medicare Advantage network box under Network/Networks.

OR

Visit Summit | Provider Search (yoursummithealth.com). Select Guest, then Medical.

Please be sure to check a member's specific benefits, as there are many benefit levels to each plan.

To check specific Medicare Advantage member benefits, copayment, or coinsurance, you may log into Benefit Tracker if you have registered access. If not, please call the Customer Service phone number listed on the member's ID care.

You can access useful provider and member information including forms, provider directory, comprehensive formulary and abridged formulary documents, coverage determination forms, drug prior authorization forms, appeal, and grievance information, etc., by visiting www.modahealth.com/medical or www.yoursummithealth.com/provider

Plan details and benefits are dependent on CMS contract renewal and can change January 1st of each year. For the most up to date information please utilize the online tools listed above or call the Customer Service phone number listed on the member's ID card.

Medicare Advantage ID card samples

Verifying member eligibility & benefits

There are four ways that you can verify member eligibility and benefits with Moda Health and its affiliate, Summit Health. It can be done electronically or by calling our Medicare Advantage customer service representatives. Due to HIPAA privacy rules, we do require the following prior to verifying information about a patient:

- Your name
- The office you are calling from
- Your Tax Identification number

To identify the patient you are inquiring about, we require the following:

- Member's subscriber identification number
- If the subscriber identification number is not known:
  - Patient's first and last name
  - Patient's date of birth
  - Patient's address or last 4 digits of the SSN on file (also required in absence of ID number)

OPTION 1: Use Benefit Tracker

When you are signed up with Benefit Tracker, you do not need to give your office information, as you have already done this during registration. By logging into Benefit Tracker with your user sign-on and password, you will be able to see copay, deductible, and out-of-pocket information as well as a link to the member's handbook. Benefit Tracker is available seven days a week, 24 hours a day.

OPTION 2: Contact us by email: medicalmedicare@modahealth.com **or** medicalmedicare@yoursummithealth.com

You will need to identify yourself as explained above, your patient and the issue for which you need assistance. Our goal is to send a response within one business day. Our email correspondent's hours are Monday through Friday from 7:30 a.m. to 5:30 p.m. PST, excluding holidays.

OPTION 3: Call Moda Health Medicare Customer Service at 877-299-9062 or Summit Health Medicare Customer Service at 844-827-2355

Armed with the very latest details on all policies and procedures, our customer service staff will always give you the best information available. You can reach them from 7:00am to 8:00pm PST, seven days a week from October 1st through March 31st. After March 31st apart from Christmas Day and Thanksgiving Day, your call will be handled by our automated phone systems on Saturday's, Sunday's, and holiday's. TTY users should call 711.

OPTION 4: Electronic Data Interchange (EDI) using HIPAA transactions

This is an electronic exchange of eligibility and benefits information using the 270/271 HIPAA transactions. This functionality is usually available through a clearinghouse or software vendor. However, if a provider desires to exchange eligibility and benefit information directly with Moda Health or its affiliate, Summit Health using this method, we will work with the provider to accomplish it.

Benefit Tracker

Benefit Tracker is designed for provider offices, clinics, and hospitals allowing designated office staff to quickly:

- Verify patient eligibility
- Verify medical benefits
    - With a link to the member's benefit handbook
- Get claim status information
- View claims online before the explanation of payment (EOP) arrives.
- Print an EOB as the claim is processed. (The information displayed is the same as the member's EOB. EOPs are currently not available in Enterprise Benefit Tracker.)
- See referrals and current PCP information. (PCP offices can make referrals (new and retroactive back to 90 days) for their patients online. To find out how to access online referral, please visit our website to view a demonstration.)

After-hours usage

Benefit Tracker is available seven days a week, from 6 a.m. to 10:30 p.m. PST, including weekends and holidays. Benefit Tracker is occasionally unavailable for site maintenance.

Getting started

- To sign up online, visit www.modahealth.com/medical and follow the link on the right side of the page.
- Download an electronic services agreement (ESA) from the website.
- Have it signed by an authorized person from your office who can make agreements for the entire clinic (i.e., office manager or director of operations).
- Email it to us at ebt@modahealth.com.
- To complete registration, have all Benefit Tracker users create their own username and password online.

For more information, contact the Benefit Tracker administrator at: 503-265-5616, toll-free at 877-277-7270 or email at ebt@modahealth.com.

Benefit Tracker is a HIPAA-compliant online service.

Urgent-emergent care

A member, a member's representative, or any provider that furnishes, or intends to furnish, services to a member may request a standard or expedited organization determination by filing a request with Moda Health or its affiliate, Summit Health.

Prior Authorizations

PPO and HMO plans require prior authorization for certain services and procedures. Please refer to the Moda Health and Summit Health Plan websites (listed below) for lists of services and procedures requiring prior authorization. You can also refer to the member's Evidence of Coverage for a list of services that may require prior authorization.

- Moda Health Prior Authorization list: modahealth.com/medical/referrals/
- Summit Health Prior Authorization list: yoursummithealth.com/provider/coverage-and-claims/prior-authorization-and-referrals
- Services performed without prior authorization will be denied to provider write-off and members may not be billed for these services.
- Please take note of the special sections below regarding authorization of advanced imaging, pain management, spine, joint surgery, and injectable medication.

Advanced imaging, pain management, spine, and joint surgery

Prior authorization requests for advanced imaging, pain management, and spine and joint surgery services will be completed by eviCore Healthcare.

For a complete list of advanced imaging, pain management, and joint and spine surgery services requiring prior authorization through eviCore, please visit the websites listed below.

- **Moda Health**: modahealth.com/medical/utilizationmanagement.shtml
- **Summit Health**: yoursummithealth.com/provider/coverage-and-claims/prior-authorization-and-referrals

Please visit evicore.com to submit prior authorization requests, check prior authorization status, and find additional resources (e.g., clinical guidelines, training resources, request clinical consultation), or call 800-918-8924.

Injectable medication program

Moda has partnered with MagellanRx to assist you in medical pharmacy management through a provider administered injectable medication program.

MagellanRx will review your prior authorization requests for specialty injectable medications that are performed in:

- an outpatient facility
- a patient's home
- a physician's office

You will find complete lists of injectable medications requiring prior authorization through MagellanRX by visiting the websites listed below.

- **Moda Health**: modahealth.com/medical/injectables/
- **Summit Health**: yoursummithealth.com/provider/coverage-and-claims/prior-authorization-and-referrals/injectables-infusion-and-speciality-drugs

Please submit routine requests through the MagellanRX website at ih.magellanrx.com. Please call 800-827-2355 for urgent or expedited requests. MagellanRx has staff available 24 hours a day for urgent requests by phone (including after hours, weekends and holidays).

Pre-service coverage determinations and non-covered services

The Centers for Medicare and Medicaid Services (CMS) established a Part C or Medicare Advantage (MA) rule about proper notice of non-coverage to MA members, including that utilizing an Advance Beneficiary Notice (ABN) is no longer allowed. Unlike fee-for-service (FFS) Medicare (or Original Medicare), only a Part C or MA plans can issue a notice of non-coverage, through an organization determination. This rule applies to all Part C Medicare Advantage plans.

All non-covered services provided by participating providers will deny as provider liability. If your patient is asking for a service which is not covered per the member's Evidence of Coverage handbook, or not clearly stated as non-covered, or is covered in some circumstances but not others, the proper avenue to notify the member of non-coverage is through a pre-service coverage determination. You will initiate a pre-service coverage determination in the same manner as you would initiate a prior authorization request. Once Moda Health has completed the pre-service coverage determination, a written approval or denial will be issued, just as we do for a prior authorization. If the services are denied and the member wants to have non-covered services anyway, the provider and member will need to have a private pay agreement. The servicing provider should forgo a claim submission for that service. This is important because if a claim is submitted after a denied pre-service coverage determination, the claim will be denied to provider write-off.

***You may request a prior authorization or Pre-service Coverage determination by calling, Faxing, or mailing*:**

Moda Health

Attn: Medicare Authorization Dept., P.O. Box 40384, Portland, OR 97240-0384

Local: 503-265-2940

Toll-free: 800-592-8283

Fax: 855-637-2666 Alternative Fax: 503-243-5105

Summit Health

Attn: Medicare Authorization dept., P.O. Box 820070, Portland, OR 97282

Toll-free: 844-931-1778

Fax: 855-637-2666 Alternative fax: 503-243-5105

Standard prior authorizations and pre-service coverage determinations for medical services are processed within 14 days of receipt of the request, and 72 hours for Part B drug requests. You and your patient will be notified of the outcome of the review in writing within the appropriate timeframe.

Expedited prior authorizations and pre-service coverage determinations for medical services are performed within 72 hours of receipt of request, and 24 hours for Part B drugs. You and your patient will be notified of the outcome by phone and in writing within the appropriate timeframe.

If a prior authorization or pre-service coverage determination cannot be approved by the Health Care Services staff, the prior authorization or pre-service coverage determination request and all available medical information are referred to a licensed physician for review.

If the prior authorization or pre-service coverage determination results in a denial of services or coverage, the written notification will include an explanation of why the service was denied and information regarding appeal rights.

Referrals

Summit Health HMO Plans require members to select a Primary Care Provider (PCP) and obtain referrals for specialty care. The Moda Health Medicare Advantage PPO Plans do not require Members to select a PCP.

Please use the forms on the Moda Health or Summit Health Plan website when requesting a referral, prior authorization, or pre-service coverage determination.

Moda Health: modahealth.com/medical/referrals/

Summit Health: yoursummithealth.com/provider/coverage-and-claims/prior-authorization-and-referrals

Moda Health and its affiliate, Summit Health provide benefits for urgent and emergency hospital admissions.

Medical emergencies can be identified when any prudent layperson with an average knowledge of health and medicine believes that one may have medical symptoms that require immediate medical attention to prevent loss of life, limb, or function of a limb. The medical symptoms may be illness, injury, severe pain, or a medical condition that is quickly getting worse.

Urgently needed services are for nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network Medicare providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that one has. Urgently needed services are for situations that include, but are not limited to, the risk of:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Medicare Pharmacy services

Part B/D covered drugs and medical supplies

Our goal is to provide our Medicare Advantage members with access to all Part B-covered medications and supplies while at the same time balancing clinical and economic considerations.

Self-Administered medications available as an outpatient prescription at retail, mail order, home infusion and long-term care pharmacies fall under the Part D or prescription drug benefit. To find out which medications are covered under Part D you can visit: 2022-Moda-Health-Formulary.pdf (modahealth.com) for Moda Medicare Advantage, formulary_pers.pdf (modahealth.com) for PERS and 2022-Summit-Health-Formulary.pdf (yoursummithealth.com) for Summit Health.

To submit Coverage determinations for medications under Part D providers should submit through the electronic prior authorization portal, Cover My Meds.

Members also now have access to Part B medications at point of sale for both Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) members at participating pharmacies.

What this means for your Part B Medicare Advantage members:

For medications and supplies covered under Part B, we encourage providers to forward our Medicare Advantage members' prescriptions to Walgreens Specialty Pharmacy. Walgreens provides a valuable service that will save money for our Medicare Advantage members on their Part B-eligible prescription drugs and supplies.

- Patients can fill prescriptions for Medicare-covered drugs and supplies. Walgreens will accept assignment and bill Moda.
- Walgreens Specialty Pharmacy will ship drugs and supplies directly to the Moda Medicare Advantage member's home or workplace — delivery is fast and free!
- Patients have access to a Medicare pharmacy provider at more than 4,500 retail Walgreens locations nationwide.
- No problems with out-of-stock medication or supplies — Walgreens maintains a full stock of all major medications.
- Patients have direct access to a pharmacist 24 hours a day, seven days, a week for questions about treatment, self-administration of injectable drugs or side effects.

Medicare Part B covered drug products include:

Cancer treatment drugs:

Myleran (busulfan)
Xeloda (capecitabine)
Cytoxan (cyclophosphamide)
Vepesid (etoposide)
Alkeran (melphalan)
Methotrexate
Temodar (temozolmide)

Immune modulating drugs:

Imuran (azathioprine)
Gengraf (cyclosporine)
SandImmune (cyclosporine)
CellCept (mycophenolate mofetil)
Prednisone 5mg
Prednisolone 5mg
Rapamune (sirolimus)
Program (tacrolimus)

Inhalation solutions:

Albuterol
Ipratropium
Isoproterenol
Metaproterenol

Diagnostic supplies:
Diabetic test strips

Vaccines

The Medicare Advantage prescription drug benefit covers several vaccines (including vaccine administration). The amount the member will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, the member may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, the member will be receiving the vaccine from someone who is not part of our pharmacy network and that the member may have to pay for the entire cost of the vaccine and its administration in advance if the member receives the vaccine at your office. The member will need to mail in the receipts, and then the member will be reimbursed. The following chart provides examples of how the member may obtain a vaccine (including its administration) under our plan. Actual vaccine costs will vary by vaccine type and by whether the member's vaccine is administered by a pharmacist or by another provider.

Remember the member is responsible for all the costs associated with vaccines (including their administration) during the deductible or coverage gap phases of their benefit.

If the member obtains the vaccine at:	And gets it administered by:	The member pays and is reimbursed
The pharmacy	**The pharmacy (not possible in all states)**	Members can expect to have a $0 Copay at in-network Pharmacies and through in-network providers.
Their doctor	**Their doctor**	The member pays their doctor up front for the entire cost of the vaccine and its administration. The member submits the receipts to Moda. The member is reimbursed the amount paid less the normal copayment for the vaccine (including administration) less any difference between the amount the doctor charged and what we normally pay.

The pharmacy	**Their doctor**	The member pays the co-payment/coinsurance at the pharmacy and then the full amount charged by their doctor for administering the vaccine. The member submits the receipt to Moda. The member is reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay.

Medicare parts B/D coverage issues

The table below provides a quick and easy reference guide for the most frequent B/D coverage determination scenarios facing Part D plans and Part D pharmacy providers. It does not address all potential situations. For more extensive discussion, please refer to the Medicare Part B vs. Part D Coverage Issues document available at: Appendix C, Chapter 6 -Medicare Prescription Drug Manual

Please note that Part B limits its coverage to only certain medication and for some health conditions. These Part B medications often require administration by a provider (i.e., injections certain vaccines, infusions, etc.). Whereas Part D medications offers a wider range of prescription medications generally available through retail pharmacies and are self-administrable. You can find which medications require a B versus D determination by looking at our posted formularies or PA Criteria at Moda Health.com. Requests for B versus D medications can be submitted by Providers to the pharmacy department through the electronic prior authorization portal via Cover My Meds.

MA: 2022-Moda-Health-Formulary.pdf (modahealth.com)

PERS: formulary_pers.pdf (modahealth.com)

Summit: 2022-Summit-Health-Formulary.pdf (yoursummithealth.com)

Prior authorization guidelines:

MA: Moda-Health-MA-prior-authorization-guidelines.pdf (modahealth.com)

PERS: Moda-Health-MA-prior-authorization-guidelines.pdf (modahealth.com)

Summit: Summit-Health-MA-prior-authorization-guidelines.pdf (yoursummithealth.com)

Part B coverage categories	Part B coverage description	Retail and Home Infusion Pharmacy setting	LTC Pharmacy setting	Comments
Durable Medical Equipment (DME) Supply Drugs **NOTE: Only available for beneficiaries residing in their "home"** [1]	Drugs that require administration via covered DME (e.g., inhalation drugs, IV drugs "requiring" [2] a pump for infusion, insulin via infusion pump) [3]	**Part B**	**Part D** Because most LTC facilities are not considered a beneficiary's "home" [4]	Blood Glucose Testing Strips and Lancets covered under Part B DME benefit are never available under Part D because they are not Part D drugs.
Drugs furnished "incident to" a physician's service	**Injectable/ Intravenous drugs** 1) Administered "incident to" a physician service and 2) Considered by Part B carrier as "not usually self-administered".	**Part D** Because a pharmacy cannot provide a drug "incident to" a physician's service (Only a physician office would bill Part B for "incident to" drugs).	**Part D** Because a pharmacy cannot provide a drug "incident to" a physician's service (Only a physician office would bill Part 8 for "incident to" drugs).	Not covered by Part B because a pharmacy cannot provide a drug incident to a physician's service (i.e., only a physician office would bill Part B for "incident to" Drugs).

Part B coverage categories	Part B coverage description	Retail and Home Infusion Pharmacy setting	LTC Pharmacy setting B/D coverage	Comments
Immunosuppressant Drugs	Drugs used in immunosuppressive therapy for beneficiaries that received transplant from Medicare approved facility and were entitled to Medicare Part A at time of transplant (i.e., "Medicare Covered Transplant").	**B or D:** Part B for Medic are Covered Transplant Part D for all other situations	**B or D:** Part B for Medicare Covered Transplant Part D for all other situations	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.
Oral Anti-Cancer Drugs	Oral drugs used for cancer treatment that contain same active ingredient (or pro- drug) as injectable dosage forms that would be covered as 1) not usually self- administered and 2) provided incident to a physician's service	**B or D:** Part B for cancer treatment Part D for all other indications	**B or D:** Part B for cancer treatment Part D for all other indications	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.

Part B coverage categories	Part B coverage description	Retail and Home Infusion Pharmacy setting	LTC Pharmacy setting B/D coverage	Comments
Immunosuppressant Drugs	Drugs used in immunosuppressive therapy for beneficiaries that received transplant from Medicare approved facility and were entitled to Medicare Part A at time of transplant (i.e., "Medicare Covered Transplant").	**B or D:** Part B for Medicare Covered Transplant Part D for all other situations	**B or D:** Part B for Medicare Covered Transplant Part D for all other situations	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.
Oral Anti-Cancer Drugs	Oral drugs used for cancer treatment that contain same active ingredient (or pro-drug) as injectable dosage forms that would be covered as 1) not usually self-administered and 2) provided incident to a physician's service	**B or D:** Part B for cancer treatment Part D for all other indications	**B or D:** Part B for cancer treatment Part D for all other indications	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.
Oral Anti-emetic Drugs	Oral anti-emetic drugs used as full therapeutic replacement for I V anti-emetic drugs within 48 hours of chemo	**B or D:** Part B within 48 hours of chemotherapy Part D all other situations	**B or D:** Part B within 48 hours of chemotherapy Part D all other situations	Participating Part B pharmacies must bill the DMERC in their region when these drugs are covered under Part B.

Part B coverage categories	Part B coverage description	Retail and Home Infusion Pharmacy setting B/D coverage	LTC Pharmacy setting B/D coverage	Comments
Parenteral Nutrition	Prosthetic benefit for individuals with "permanent" dysfunction of the digestive tract. If medical record, including the judgment or the attending physician, indicates that the impairment will be long and indefinite duration, the test of permanence is met.	**B or D:** Part B if "permanent" dysfunction of digestive tract Part D for all other situations	**B or D:** Part B if "permanent" dysfunction of digestive tract Part D for all other situations	Part D does not pay for the equipment/supplies and professional services associated with the provision of parenteral nutrition or other Part D covered infusion therapy.

[1] In addition to a hospital, a SNF or a distinct pa1 SNF, the following LTC facilities cannot be considered a home for purposes of receiving the Medicare Part B DME benefit: A nursing home that is individually certified as both a Medicare SNF and a Medicaid nursing facility (NP).
A Medicaid-only NF that primarily furnishes skilled care.
A non-participating nursing home (i.e., neither Medicare nor Medicaid) that provides primarily skilled care; and an institution that has a distinct part SNF and which also primarily furnishes skilled care.

[2] The DMERC determines whether a JV drug requires a pump for infusion.

[3] The DMERC does a medically necessity determination regarding whether a nebulizer or infusion pump is medically necessary for a specific drug/condition.

[4] If a facility does not meet the criteria in footnote, it would be considered a home, and Part B could cover the drugs.

Claim filing guidelines

Reimbursement Policy Manual

Our Reimbursement Policy Manual addresses several major administrative policies, payment policies and other significant reimbursement issues. The policies it contains affect and apply to you as a contracted provider. The manuals can be found on the following websites:

Moda Health: Medical Providers: Reimbursement Policy Manual (modahealth.com)

Summit Health: Summit Health reimbursement policy manual (yoursummithealth.com)

Please review the policies posted and check back periodically for updates and additional topics.

Filing a claim

Contracted providers agree to bill Moda Health and its affiliate, Summit Health directly for covered services provided to our members. Once coverage has been identified through the Medical Member Services department or online using Benefit Tracker, members should not be asked for payment at the time of services, except for copayments.

Use your provider number

For claims to be processed correctly, each claim must include the correct Tax ID Number (TIN). If you are a clinic with multiple physicians or other providers, the name of the individual who provided the service also must be noted. If this information is not provided, the claim may be returned for resubmission with the missing information. Please include your UPIN in Box 33, PIN # field, for all Medicare Advantage claims.

Acceptable claim forms

Please file all claims using the standard CMS (formerly HCFA) 1500 or UB92/UB04 claim forms or electronic equivalents. We do not supply claim forms to providers.

Electronic submission of claims is highly encouraged. There are many benefits to enrolling in electronic claim submission, including improved turnaround times and accuracy. If you would like information on billing claims electronically, please contact our Electronic Data Interchange (EDI) department at 1-800-852-5195 or 503-243-4492.

Incomplete paper claim forms may be returned for resubmission with the missing information. Please do not use highlighters on paper claims. This has the effect of blacking out the information that was highlighted when the claim is scanned by our systems.

For more information, please see our websites at:

Moda Health: Claims and appeals (modahealth.com);

Summit Health: Billing and claims (yoursummithealth.com), or

Go to www.nubc.org

Timely filing guidelines

We require that all eligible claims for covered services be received in our office within 90 days after the date of service. Failure to furnish a claim within the 90 days shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within the required period, provided it is submitted as soon as reasonably possible.

Claims received later than 12 months after the date of service shall be invalid and not payable. The absence of legal capacity constitutes the only exception to this policy.

When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination." As such, the denial for lack of timely filing is not subject to appeal. The provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if payment had been made.

If an explanation of payment (EOP) is not received within 45 days of submission of the claim, the billing office should contact Medical Member Services or check Benefit Tracker to verify that the claim has been received. When submitting a claim electronically using an electronic claims service or clearinghouse, it is important to check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

All information required to process a claim must be submitted in a timely manner (e.g., date of onset, accident information, medical records as requested). Any adjustments needed must be

identified in the adjustment request and must be received within one year of the date the claim was originally processed for the request to be considered.

Records and records requests

All information required to process a claim must be submitted in a timely manner (e.g., date of onset, accident information, medical records as requested). The provider submitting the claim is responsible for providing, upon request, all pertinent information and records needed to support the services billed and/or related reviews and carrier responsibilities. When the billing provider receives a letter or fax requesting information needed for a review, if the requested documents and information are not received by our team within the required timeframe, the record is deemed not to exist, and the services not documented. If the documentation is incomplete or insufficient to support the services, then the service or item will be considered as not documented. Please ensure that your response to records requests is both prompt and complete. See RPM039, "Medical Records Documentation Standards." See also Claim filing guidelines, Timely filing.

It is our policy not to pay a fee for the routine completion and mailing of claim forms, insurance billings, or related medical records. Most policies exclude "separate charges for the completion of records or claim forms and the cost of records." See reimbursement policy #RPM005, "Records Fees, Copying Fees."

Split claims

As much as possible, all procedure codes for a single date of service are to be submitted at the same time on a single claim form. Submitting additional charges later, on a separate claim creates a split claim for the date of service and makes correct processing of the claim more difficult. Split claims are to be a rare occurrence rather than a habitual billing pattern.

If additional surgical procedures need to be submitted, then a corrected claim needs to be submitted rather than a split claim reporting only the additional surgical codes. The corrected claim needs to report all the surgical codes for the entire surgical session, including the codes previously billed, to ensure proper fee calculation and avoid any confusion about whether codes are being changed or added. These claims are to be clearly marked with a notation indicating "corrected claim." See further information on corrected claims below.

Resubmitting and/or duplicate claims

If a claim is denied, please refer to the explanation code to help determine what issue needs to be addressed before resubmitting the claim. Our claims system identifies additional identical claims as duplicates.

Resubmitting a denied claim without taking a corrective action will result in another claim denial. In some cases, a corrected billing is needed. See instructions below.

Corrected billings

All claims submitted as corrected billings to previously submitted claims must be clearly identify they are corrected in one of the following ways:

- Submit a corrected claim electronically via a clearinghouse.
    - Institutional Claims (UB): Field CLM05-3 = 7 (7 = replacement or corrected; 8 = voided or cancelled) and Ref*8 = **Original Claim Number.**
    - Professional Claims (CMS): Field CLM05-3 = 7 (7 = replacement or corrected; 8 = voided or cancelled) and Ref*8 = **Original Claim Number.**
- Submit a corrected paper claim to:

  Moda Health

  Attention: Corrected Medical Claims

  P.O. Box 40384

  Portland, OR 97240

  OR

  Summit Health

  Attention: Corrected Medical Claim

  P.O. Box 820070

  Portland, OR 97282

    - Institutional Claims (UB): The **original claim number** must be typed in field 64 (UB-04) with the corresponding frequency codes (7 = replacement or corrected; 8 = voided or cancelled) in field 4 of the UB-04 form.
    - Professional Claims (CMS): The **original claim number** must be typed in field 22 (CMS 1500) with the corresponding frequency codes (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 form.
    - A handwritten or stamped notation indicating "corrected claim" may also be added.

The corrected claim must include all procedures and line items for the date of service in question, even if they were submitted on the original claim. Please include a brief note explaining what was changed or corrected and why. Attach records for the services billed to verify the coding change is appropriate. Corrected claims received without accompanying records may result in denials.

Correct coding and billing

Claims are to be submitted using valid codes from HIPAA-approved code sets. Claims must be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, AHA Coding Clinic, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Report the most specific CPT or HCPCS 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 may 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 need to be attached as appropriate. The absence of a description for an unlisted code is a billing error.

Diagnosis code requirements

ICD-10-CM codes must be reported to the highest level of specificity available. Incomplete codes may result in denial or delay of claims. These requirements apply to all diagnosis codes billed in any position, on all claims, and is applicable in all settings from all provider types.

Diagnosis codes must also be specific to accurately reflect the laterality of the condition and the services. When an unspecified laterality diagnosis code is submitted, a denial will occur.

Certain diagnosis codes are not eligible to be reported in the principal diagnosis field. Coding rules require that manifestation diagnosis codes, external causes of morbidity/injury codes, and certain other diagnosis codes with specific sequencing instructions must always be reported as secondary to another diagnosis code.

CMS also identifies a list of specific diagnosis codes which are unacceptable as a principal diagnosis on facility claims. Inpatient facility claims billed with an invalid primary diagnosis code for the setting will deny with explanation code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis).

To view our Diagnosis Code Requirement reimbursement policies RPM053 and RPM054.

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 may 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 are to be attached as appropriate. The absence of a description for an unlisted code is a billing error.

Surgical and medical supplies

Since there are many HCPCS Level II codes that specify supplies in more detail, 99070 is never the most specific code available to use when billing miscellaneous surgical and medical supplies. Established HCPCS Level II codes are to be reported instead. An allowance for commonly furnished medical and surgical supplies, staff and equipment is included in the practice expense portion of a procedure's RVUs, as established by CMS, and published in the Federal Register. Additional charges for equipment and supplies (e.g., gloves, dressings, syringes, biopsy needles, EKG monitors/leads, oximetry monitors/sensors, etc.) are not appropriate. These items are considered incidental to the other procedures performed and denied as provider write-off. See Reimbursement Policy RPM021, "Medical, Surgical, and Routine Supplies (including but not limited to 99070)."

90-day supply limit for ongoing medical supplies

For medical supplies with ongoing regular use such as diabetic supplies, ostomy supplies, urological supplies, etcetera, we will allow pharmacies and DME suppliers to dispense, ship, and bill up to a 90-day supply of the usual medical needs of the member at a time. See Reimbursement Policy RPM072, "Supply Limits for Ongoing Medical Supplies" for more information.

Use NDC numbers when billing drugs and medications

Please include NDC numbers in addition to the HCPCS code when billing for drugs, to facilitate accurate pricing of the drug supply. See Reimbursement Policy RPM015, "Drugs and Biologicals, Wastage and/or Discarded Amounts (Modifier JW)" for information about documenting and billing wasted or discarded amounts.

Use NDC numbers when billing Parenteral/Enteral Nutrition (PEN) products

When submitting claims for parenteral and enteral nutrition (PEN) products, in addition to billing HCPCS codes B4100 – B5200, B9998, and B9999, please include NDC numbers when available to facilitate accurate pricing of the PEN supply.

Reduced or discontinued procedures

See reimbursement policies RPM003, "Modifier 52 — Reduced Services," RPM018 "Modifier 53 — Discontinued Procedure," and RPM049, "Modifiers 73 & 74 - Discontinued Procedures For Facilities."

When modifiers 52 Reduced Services or 53 Discontinued Procedure are submitted on a line item, these claims may be reviewed. When modifier 52 or 53 is valid, the reduced or discontinued procedure will be reimbursed at a rate that is reduced from the usual allowable.

A letter or brief statement needs to be attached to the claim or included with the records indicating what was different about the reduced procedure, or at what point the procedure was discontinued and why. For best review results, please ensure the statement includes an estimate of the percentage of work performed as compared to the work usually required or performed for the procedure code. For example, if a CT scan is billed with modifier 52, a notation that "only 7 slices done, 15 are usually taken" clearly indicates the nature and amount of the reduction. This information needs to be attached to paper claims. For electronic claims, please be prepared to supply this information for review.

Modifier 53 Discontinued Procedure may not be considered separately reimbursable or valid if other procedures were completed during the same session.

Billing tips to avoid delays

Here are some helpful hints to reduce claims processing time:

- Submit claims electronically.
- Before submitting a claim, verify that the plan information is correct and that the member's relationship to the subscriber is correct.
- Complete all required fields on the claim form. Ensure all Diagnosis codes, Procedure codes, Modifiers, Location (Place of Service), Type of Bill, Type of Admission, and Source of Admission codes are valid for the date of service.
- Ensure all Diagnosis and Procedure codes are appropriate for the age of the member.
- Ensure all Diagnosis codes are coded to their highest number of digits available.
- Ensure member is eligible for services during the time-period in which services were provided.
- Ensure provider has received authorization to provide services to the eligible member, when appropriate.
- If the member is covered by more than one Moda Health or Summit Health program, submit one claim indicating the name of the subscriber, subscriber ID, employer (if applicable) and group number for both plans. If covered by another carrier, include the name, address, and policy number of the other carrier.
- If a member has primary insurance through another carrier, the EOP from that insurance company must accompany the claim for consideration of payment, if the claim is being filed on paper. If the claim is being filed electronically, the payment information from the primary carrier needs to be sent electronically along with the claim information
- Please contact our Medicare Advantage Customer Service or check Benefit Tracker before submitting duplicate claims:
    - Rebilling without contacting us slows our turnaround time and delays payment.
    - Check Benefit Tracker to see the status of a claim. If you haven't registered for this free online service and would like more information, see the Moda Health website at www.modahealth.com/EBTWeb/ or contact the Benefit Tracker administrator by phone at 503- 265-5616 or 1-877-277-7270, or by fax at 503-948-5577.
    - If you receive an EOP indicating that your claim has already been processed before you receive a check, this indicates your rebill was unnecessary. The claim was processed and is pending for the next scheduled payment date.
- DO NOT USE HIGHLIGHTERS ON PAPER CLAIMS OR MEDICAL RECORDS. This has the effect of blacking out the information that was highlighted when the claim is scanned by our systems.

Common reasons for denied, paid at a lower benefit, or returned claims

- Member is not eligible. A member's card is NOT a guarantee of eligibility. (See the "Member eligibility and benefit verification" section in this manual.)
- Coverage is not yet effective or has terminated.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from required fields. Example: "Statement From," "Statement Through," "Service From," or "Service To" dates.
- Claim received with incomplete information. Please remember to include the following:
    - Subscriber ID
    - Group number
    - Date of birth
    - CPT Code or HCPCS code
    - ICD-10 code to the highest specificity
    - Full name and address of Provider with the tax ID number
    - No authorization on file for procedure.
    - Member has other primary coverage and EOB was not received with claim.
- Procedure or service is a non-covered service. Please contact Medical Member Services to verify if the procedure is a covered service or if there are any questions.

Multiple procedure reductions

See Reimbursement Policy RPM022, "Modifier 51 — Multiple Procedure Fee Reductions."

We apply multiple procedure reductions to procedure codes with a CMS multiple procedure indicator of "1," "2," "3," "4," "5," "6," and "7."

For procedure codes with a multiple procedure indicator or "1," "2," or "3":

- All procedure codes, including bilateral procedures, performed in one operative session must be submitted together. Splitting the codes on separate claims (fragmenting) may lead to incorrect payment of services.
- Surgical codes are subject to multiple procedure cutbacks, unless they are designated as either exempt from modifier 51 or as "add-on" codes. We consider the primary procedure at 100 percent of allowance, and the remaining codes at 50 percent of allowance.
- Regardless of the order in which the procedures are listed on the claim, the surgical code with the highest allowable fee (before the bilateral procedure adjustment) will be considered the primary procedure (processed at 100 percent) for the purpose of calculating multiple procedure adjustments. This ensures that the best possible total reimbursement is issued for the allowed surgical codes.
- Surgical codes that are designated as "add-on" codes are not eligible to be billed without the primary surgical code that they are added onto (base code). Add-on codes will be considered at 100 percent of allowance (multiple procedure indicator of "0" or "9"). Surgical codes that are designated as modifier 51-exempt will be considered at 100 percent of allowance (multiple procedure indicator of "0" or "9").

For procedure codes with CMS multiple procedure indicators of "4," "5," "6," or "7":

We apply the following multiple procedure reduction rules:

- Multiple radiology procedure reductions (indicator of "4").
- Multiple therapy services reductions (indicator of "5").
- Multiple diagnostic cardiovascular services reductions (indicator of "6").
- Multiple diagnostic ophthalmology services reductions (indicator of "7").

For details of these reductions, see Reimbursement Policy RPM022, "Modifier 51 — Multiple Procedure Fee Reductions."

Modifiers for surgical codes

When surgical CPT codes are billed with certain modifiers, records will be needed to correctly process the claim. Please refer to the list below and attach the needed records to the claim when the claim is submitted. This will avoid unnecessary delays in processing for us to request the needed records, and it will ensure that you receive payment for services as soon as possible.

	Modifier description	Records needed
-22	Unusual procedural services	Operative report and summary explanation of unusual circumstances (see reimbursement policy RPM007, "Modifier 22 — Increased Procedural Services").
-52	Reduced services	Statement indicating how the service was reduced and the percentage of work actually done is compared to the usual work required, and records for the reduced code or service billed (see reimbursement policy RPM003, "Modifier 52 — Reduced Services") and RPM049, "Modifiers 73 & 74 - Discontinued Procedures for Facilities.").
-53	Discontinued procedure	Medical records documenting procedure planned, at what stage it was discontinued, and why. Indicate the percentage of work completed as compared to the complete procedure. (See reimbursement policies RPM018, "Modifier 53 – Discontinued Procedure" and RPM049,"Modifiers 73 & 74 - Discontinued Procedures for Facilities.")
-58	Staged or related procedure	Preoperative history and physical and operative report for original and current surgeries (see reimbursement policy RPM010, "Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures").
-59	Distinct procedural service	Operative report and/or chart notes (see reimbursement policy RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")

-62	Two surgeons	For procedure codes with a co-surgeon indicator of "1" on the MPFSDB: All operative reports (covering work of all surgeons). Documentation of reason for necessity of two surgeons. (See reimbursement policy RPM035, "Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons).")
-66	Surgical team	For procedure codes with a team surgeon indicator of "1" on the MPFSDB: All operative reports (covering work of all surgeons). Documentation of reason for necessity of team of more than two surgeons. (See reimbursement policy RPM035, "Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons).")
-76	Repeat procedure by same physician	Operative report and/or chart notes
-77	Repeat procedure by another physician	Operative report and/or chart notes
-78	Return to the operating room for a related procedure	Preoperative history and physical, and operative report for both surgeries (see reimbursement policy #RPM010, "Modifiers 58, 78 and 79 — Staged, Related and Unrelated Procedures").
-79	Unrelated procedure or service by the same physician during the postoperative period	Preoperative history and physical, and operative report for both surgeries (see reimbursement policy RPM010, "Modifiers 58, 78 and 79 — Staged, Related and Unrelated Procedures").
-XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter	Operative report and/or chart notes (see reimbursement policy RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")
-XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure	Operative report and/or chart notes (see reimbursement policy RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")
-XU	Unusual Non-Overlapping Service, The Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of The Main Service	Operative report and/or chart notes (see reimbursement policy RPM027, "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.")

Note: When an operative report is indicated or requested, the records needed are always the most complete documentation of the procedures billed that are available. This documentation comes in various formats, depending on the type of surgical code billed and the documentation variations that exist among facilities or providers.

- If a formal, dictated operative report is available, this is always what is needed.
- If the surgical code is associated with a radiology procedure, the dictated procedure report may be considered an X-ray report by some offices or facilities.
- Depending on the extent of the procedure billed, some physicians do not dictate a formal operative report for certain surgical procedure codes. In those cases, all medical records (including dictated and/or handwritten notes and any diagrams) documenting the visit and the surgical procedure code must be submitted when the operative report is requested.

Copayments and Deductibles

Types of copayments

Medicare Advantage benefit plans have two types of cost-sharing that may be applied, in some cases after satisfaction of the deductible. The first is a flat fee or co-payment (i.e., always the same dollar amount for each visit). The second cost sharing arrangement is a percentage of charges, which is sometimes also referred to as "coinsurance." Both types of cost sharing appear in the "Copay" column on your explanation of payment (EOP).

The amount of the cost sharing will depend on the specifics of the individual member's plan. The copayment type (a flat fee or a percentage of charges) may vary, depending on the level of benefit.

To determine the amount of copayment for a scheduled service, check our online Benefit Tracker or contact the appropriate Medicare Advantage customer service department.

Multiple copayments per visit

Depending on the number of services and the procedure codes billed, a member's plan may require more than one copayment per visit.

Deductibles

Most of our Medicare Advantage plans also have some type of deductible that is applied prior to any copayments and/or coinsurance maximum provisions. The "Patient Responsibility" column on the EOP will include what amount the member is responsible for paying. You can verify if a member has met their deductible for the year by checking Benefit Tracker online or contacting our Medicare customer service representatives.

Collecting copayments and deductibles

Many offices prefer to collect all patient responsibility amounts from members at the time of service. We require that you limit up-front collections to flat-fee copayments only. Coinsurance amounts vary, based on the deductible and allowable amounts, and therefore are not predictable at the time of service.

We assign patient responsibility for deductible amounts to claims in the order that the claims are processed, not based on dates of service. Unmet deductibles (at the time of service) can be fully satisfied by other claims that are processed between the date of your service and when your claim for those services is processed.

We do require that if payments are collected at the time of service and the EOP arrives showing the total amount owed by the patient (patient responsibility field) to be less than the amount that the office has already collected from the patient, the difference must be refunded to the patient.

Coordination-of-Benefit information

Coordination of Benefits (COB) refers to the determination of which of two or more health benefit plans, including Medicare or Medicaid, will pay, as either primary or secondary payer, for medical services provided to a member. The determination of liability for payment of medical services, subject to COB, will be in accordance with applicable state and federal laws, regulations, and applicable language in the health benefit plans issued or administered by Moda Health and its affiliate, Summit Health.

Members may be eligible for coverage from another payer including, but not limited to, other individual or group health plans, liability insurers, entities providing workers' compensation or occupational disease coverage, Medicaid, or other government programs. Moda Health, its Affiliates and a Medicare Advantage participating provider will inform each other whenever a member has coverage from other payers. The provider will collect payment from third-party payers, using the provider's customary collections procedures, whenever the payers have primary responsibility to provide or pay for covered Services in accordance with the coordination of benefits or maintenance of benefits and third-party liability requirements of members' health Plans.

If we are required to pay a portion of provider's charges for covered Services not covered by other payers, we will pay the provider only that amount which, when added to the amounts paid or owed by the other payer and any co-payment, deductible, or coinsurance charges for which the member is responsible, will not exceed provider's agreed upon allowance for the services under this agreement. The provider will not bill, charge, seek compensation, remuneration or reimbursement from, or have any recourse against members, for amounts more than the agreed upon allowances.

When your patient has coverage under two or more insurance plans, one plan is considered the primary plan and pays first. The primary plan pays the benefits that would be payable if it were the only insurance coverage.

The other plan is considered the secondary plan and pays benefits after the primary plan. The EOB from the primary plan must accompany the claim for consideration of payment. The secondary plan will limit the benefits it pays according to the plan language in the member's contract.

Workers' Compensation statutes provide that Workers' Compensation insurance is primary coverage for all job-related injury or illness claims. All work-related conditions are plan exclusions, so long as the patient is not exempt from state and federal Workers' Compensation law. This exclusion applies unless the expense is

denied under the Workers' Compensation coverage. All claims for job-related injury or illness should be sent to the patient's Workers' Compensation carrier, not to Moda Health or its Affiliates.

Submitting your claims

If your patient has coverage under two insurance carriers and Moda Health or Summit Health is secondary, a copy of the EOB from the primary insurance company must accompany the claim for consideration of payment.

Clinical editing policy

Reimbursement policy #RPM002, clinical editing

We use HIPAA-compliant code editing software in the processing of medical claims to improve accuracy and efficiency in claims processing, payment, and reporting. Our clinical edit set focuses on correct coding methodologies and accurate, appropriate adjudication of claims.

Our claims editing software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifiers, and place of service codes against correct coding guidelines. The software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle.

Our clinical edit policies are based on coding conventions defined by a variety of established sources, including but not limited to:

- The American Medical Association's CPT manual
- The AMA CPT Assistant newsletter articles
- The Centers for Medicare & Medicaid Services (CMS) policies, fee schedule status indicators and guidelines
- The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (CCI) and associated policies
- Coding guidelines developed by national professional specialty societies
- Specialty clinical practice guidelines
- Clinical research and practice pattern analysis
- Clinical experience of physician reviewers
- Numerous medical journals
- Medical texts
- Medical newsletters
- Coding industry newsletters
- Public health data studies
- Proprietary health data analysis
- Other general coding and claim payment references

Upon request, we will provide either the abbreviated or the verbatim citation of the source that defines the policy standard for a specific clinical edit.

Provider inquiries and appeals

We strive to informally resolve issues on initial contact whenever possible. Before entering the appeals process, please contact Moda Health's Medicare Advantage customer service team at 877-299-9062 or Summit Health's Medicare Advantage customer service team at 844-827-2355. If the customer service team is unable to resolve the issue to the provider's satisfaction, the provider will be advised of their right to dispute the decision as described below.

Inquiry

The first time a request for review is submitted to the appeals team, it will always be considered an inquiry. A written request for information regarding claim status, member eligibility, payment methodology (including bundling/unbundling, multiple surgery rules, etc.), medical policy, coordination of benefits or third-party issues are examples of provider inquiries. An inquiry must be received within 12 months of the claim processing date. All supporting documentation submitted by the provider will be reviewed, along with the member's benefit plan.

The provider appeals unit will review the materials submitted, with a goal of sending written notification of its decision within 45 business days of receipt of the inquiry and notification of the provider's right to the next step in the appeal process. If the provider disagrees with Moda Health or its affiliate, Summit Health's determination in response to the inquiry, the provider may file a first-level provider appeal.

First-level appeal

Appeals must be received within 12 months of the claim processing date. The appeal will be reviewed by the director of claims and the medical director in accordance with the terms of the contract. Moda Health and its affiliate, Summit Health will review the materials submitted with a goal of sending written notification of its decision and notification of the provider's right to the next step in the appeal process within 45 business days of receipt of the appeal.

Final appeal

If, after inquiry and appeal determinations, the appeal remains unresolved to the satisfaction of the provider, a final appeal may be made in writing to an appeals committee comprised of the senior director, vice president or senior vice president of claims, and director or vice president of professional relations. A final appeal must be submitted within 60 days of the determination on the appeal. A hearing will be held, unless waived by the parties, and the decision of the committee will be final and binding on all the parties in accordance with applicable state law.

How to submit a provider inquiry or appeal

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

- The provider's name
- The provider's Tax Identification number
- Contact name, address, and phone number
- Patient's name
- Member identification number
- Date of service and claim number or authorization number if no claim
- An explanation of the issue the provider believes is incorrect, including supporting medical records or documentation when applicable
- For claims involving coordination of benefits, the name and address of the primary carrier

Inquiries and appeals should be submitted to:

Moda Health Plan, Inc.

Provider Appeal Unit

P.O. Box 40384 Portland, OR 97240

OR

Summit Health Plan, Inc.

Provider Appeal Unit

P.O. Box 820070

Portland, OR 97282

Member appeals

Moda Health and its affiliate, Summit Health provide an internal multilevel procedure for members to obtain timely resolution of their appeals. The statutes and regulations that govern the member's Medicare Advantage plan determine the levels of review of the appeal. Persons not involved in any previous decisions review the appeal. The member must file the appeal within 60 calendar days of the date of the notice of the organization determination for a prior authorization or claim.

A written response is sent to the member or member's representative within the timeframe specified in the member's Evidence of Coverage.

Our Appeal Units perform a thorough investigation of the appeal. The written response advises the member of the decision related to each element of the appeal and the reason for the decision. The written response also provides information on the member's right to an additional appeal through the independent review entity contracted by CMS.

Providers can appeal on behalf of a member (with the member's permission) for pre-service denials.

Recovery of over/underpayments

Either party will be entitled to request an adjustment of payment if they notify the other of an overpayment or underpayment within 12 months following the date of payment in question. The 12-month limitation does not apply in cases involving coordination of benefits, claims involving fraud or certain claims involving subrogation. Any request for a corrective adjustment must specify the reason as to why the requesting entity believes it is entitled to an adjustment. For claims involving coordination of benefits, the request for refund must be made within 30 months after the date that the payment was made, and any such request must specify the reason the party believes it is owed the refund or additional payment. It must include the name and mailing address of the entity that has primary responsibility for payment of the claim or who has disclaimed responsibility for payment of the claim.

If a party fails to contest a payment adjustment in writing within 30 days of its receipt of the request for adjustment, the request is deemed accepted and the refund must be paid. If the provider contests the refund request, the dispute will be processed in accordance with the provider appeal procedure. If we do not receive payment or a request for appeal within 90 days of the provider's receipt of the written request, then the amount owed may be deducted from the amounts due the provider on the next claim(s) processed for the provider, until the debt is settled. Neither party may request that a corrective adjustment be made any sooner than six months after receipt of the request. Nothing prohibits the provider from choosing at any time to refund Moda Health or its Affiliates any payment previously made to satisfy a claim.

Overpayments

When there is a need to send Moda Health or Summit Health a check for remittance of overpayments, please include a copy of the refund request letter or the following information to ensure that the refund is correctly posted to the appropriate account:

- Patient name
- Member identification number
- HIPAA member ID
- Date of birth
- Date of service
- Claim number (if known)
- Reason for refund

Should you disagree with our request for a refund, please contact Moda Health Medicare Advantage Customer Service at 503-265-4762 or 877-299-9062 or Summit Health Medicare Advantage Customer Service at 844-827-2355 to determine a resolution.

If you have received an overpayment but have not yet received a refund request from Moda Health, you may wish to use the Provider Refund Submission Form, or you may use the Provider Refund Submission Form for Summit Health. Simply print the applicable form, complete all appropriate information and mail with your refund to the address shown on the bottom of the form.

To request an adjustment to a claim, first contact

Moda Health Medicare Advantage Customer Service:

Via telephone at 503-265-4762 or 877-299-9062, or

Via email at medicalmedicare@modahealth.com

Summit Health Medicare Advantage Customer Service:

Via telephone at 844-827-2355, or

Via email at medicalmedicare@yoursummithealth.com

If your request is not resolved to your satisfaction, send a written request to us. The letter must indicate the specific claim you are writing about, and it must state clearly and

concisely why you feel it should have been paid or paid at a higher level. Medical records, including a copy of the EOP for the claim in question, or other medical documentation supporting your reasons must also be included with the letter. Additional information may be found in the “Provider inquiry/provider appeals” section of this manual.

Mail your letter of request to:

Moda Health Plan, Inc.

Attn: Appeal Unit

P.O. Box 40384 Portland, OR 97240

OR

Summit Health Plan, Inc.

Attn: Appeal Unity

P.O. Box 820070

Portland, OR 97282

Third Party Liability (Subrogation)

Third Party Liability (TPL) refers to a situation where another person or company may be responsible or liable for an injury that caused the medical expenses incurred by the insured person. This liability includes the responsibility to pay for the medical expenses that result from the illness or injury. Even accidents that involve only one person may have third party liability. For example, in a one-car motor vehicle accident, the driver's auto insurance carrier is the third party.

Subrogation means the assumption of another's legal right to collect a debt or damages. For example, when we pay claims that are determined to be the responsibility (or liability) of a third party, we are entitled to assume the member's legal right to collect that portion of the debt or damages resulting from the illness or injury. This does not eliminate the member's right to seek to collect damages above and beyond the amount of the claims paid by Moda Health or its affiliate, Summit Health.

Is this Third-Party Liability?

Examples of situations that may involve Third Party Liability are:

- Any type of injury involving a motor vehicle
    - ATV accidents
    - Auto vs. Auto
    - Auto vs. Bike
    - Auto vs. Pedestrian
    - Auto vs. Tree, Ditch, Building, etc.
    - Hand in car door, fall from pick up, etc.
    - Boating accidents
- Prescription drug complications
- Dog bites
- Falls in public places (buildings, sidewalks, stores, schools, etc.)
- Fights
- Fires
- Injuries at school or on a playground
- Medical malpractice
- Shootings

How do we handle possible Third-Party Liability situations?

When we have information that Third Party Liability may exist, a Third-Party Reimbursement Questionnaire and Agreement is mailed to the member. Related claims continue to be considered for normal plan benefits during the investigation process as Medicare Advantage plans are pay and pursue. If a response to the questionnaire is not received within 30 days a second questionnaire is mailed to the member.

We seek a signed **Third-Party Reimbursement Questionnaire and Agreement** to help ensure that when a settlement is reached, the money owed to Moda Health and its affiliates for these claims is repaid. The **Third-Party Reimbursement Questionnaire and Agreement** asks for information to help clarify who is responsible for the medical expenses of the illness or injury situation. The agreement is sent with a letter to a member when information (from a claim, telephone call or accident questionnaire) indicates a possibility that another party may be involved in an injury or illness.

If Moda Health or its affiliates are aware that an attorney is already representing the member, the attorney will be contacted. The agreement contains a statement the member must sign agreeing to reimburse Moda Health or Summit Health if a settlement is reached.

TPL cases often involve disputes, negotiations, court cases or other circumstances that result in a delay of months or years before payment is obtained from the responsible party (an individual or another insurance carrier) for the medical expenses resulting from the injury. During the delay period, we continue to process claims until a settlement is reached, so long as the member and/or the member's attorney continue to honor our subrogation rights.

We log and track all payments in preparation for the final settlement. Our subrogation staff will continue to work with the member and the member's attorney until the settlement is received and all aspects of the case have been resolved.

Call share

Providers with whom you share call should be contracted with our Medicare Advantage network. When a claim is received from a provider who's contracted with Moda Health or Summit Health, the Medicare Advantage level of benefit will apply. If a non-contracted provider renders services, generally a lesser benefit will be issued, with more cost to the member.

We recognize there may be times when your call share provider is a non- contracted provider. In these situations, it is necessary for the claim to be stamped "call share" and specify for whom the provider is covering. This will alert the claims processor to apply the higher level of benefit. If the claim does not indicate call share, the provider will need to contact the appropriate Medicare Advantage Customer Service department upon receipt of the EOP to request an adjustment. The call share provider will be reimbursed at the contracted level, with the member to be held harmless.

Medical record, office site, access and after-hour standards and audits

Practice standards — NCQA compliance

The provider is responsible for complying with medical/treatment recordkeeping, office site, access and after- hours standards as part of the contract between Moda Health, its affiliates, and the provider. Following NCQA guidelines, we monitor member grievances and performs surveys and audits to ensure that standards are met.

Practitioners subject to audits:

- All practitioners
- All specialties

Noncompliant practitioners:

- May appeal an audit score and request a review of the files and ratings.
- Are required to submit a corrective action plan and complete a re-audit within six months.
- Continued noncompliance may result in termination of participation.

We conduct office site audits to assess the quality, safety, and accessibility of provider office sites. The threshold that triggers a site visit is two member complaints received within a consecutive six-month period. The member complaints that are monitored for quality, safety and accessibility are:

- Physical access
- Physical appearance
- Adequacy of waiting and examining room space
- Patient safety
- Adequacy of medical/treatment recordkeeping

A site review is performed within 60 days of receipt of the second complaint. We will institute corrective actions for clinics that do not meet performance standards and evaluate the effectiveness of the improvements at least every six months, until the deficiencies are resolved. The medical director will review the corrective action plan and specify the date for completion and re-review.

Medical records standards

- Standards for all medical recordkeeping systems
- The practice has a documented HIPAA-compliant policy on the security, privacy, storage, and transport of patient data.
- The practice uses our methods for storing and transporting all patient data that comply with applicable privacy and security laws — i.e., encrypt all backup data before transport; store data at a secure off-site facility (bank vault) or in a fireproof safe on the premises.
- Medical records and patient information are not accessible by non-authorized individuals.
- There is a written procedure for release of patient information that includes a system for tracking to whom medical records are released and which staff has access to the medical records.
- There is a procedure in place to address whether the patient has executed an Advance Directive and/or Physician Orders for Life-Sustaining Treatment (POLST).

Office site standards

Our office site standards include requirements of the Occupational Safety and Health Act (OSHA), The Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA). The office site will provide and ensure:

- Working fire extinguishers and fire exit doors that are clearly marked
- Reasonable accommodations (exam room, parking, elevator, restroom) for patients in wheelchairs or other walking-assist devices and for the sight- and/or hearing-impaired
- Adequate waiting room space for the volume of people to be seen
- Routine maintenance inside and outside, performed on a regular basis
- At least two exam rooms per practitioner (applies to medical practices only)
- Provisions for non-English-speaking patients (this includes written privacy policy resources for translating the privacy policy into other languages)
- Provisions for safe, tamper-proof disposition of syringes and needles in each exam room
- Appropriate disposal of biohazardous material
- Controlled substances stored in a locked space, with access restricted to authorized individuals
- Advance Directives available

Privacy and security standards

The following privacy and security standards are required:

- Restrict the patient's medical records to only those authorized by the patient or persons involved with the patient's direct medical care.
- Ensure that people in the reception area cannot overhear discussions of confidential patient matters or see confidential papers or computer screens.

Physical access

All participating provider sites must comply with the requirements of the Americans with Disabilities Act of 1990, including, but not limited to, street-level access or an accessible ramp into the facility and wheelchair access to the lavatory.

Timely access

To ensure that our members have access to high-quality service and medical care in a timely manner, we have established the following standards, which we monitor through surveys, audits, and member complaints:

- Our access standards for medical services:
    - Medical coverage is available 24 hours, 7 days a week.
    - Emergency needs are immediately assessed, referred and/or treated.
    - Members requiring urgent, acute care are seen within 24 hours of request.
    - Established members requesting an appointment for stable or chronic conditions that are asymptomatic at the time of the call are scheduled within 30 calendar days of the request.

After-hours care

The provider must be accessible 24 hours a day, seven days a week. The provider is responsible for establishing an on-call arrangement with another participating provider for continuous coverage to meet the medical needs of our members.

We verify on-call and after-hours coverage at the time of initial credentialing and at each re- credentialing and monitors through member complaints and, if applicable, the office site audit and other surveys.

Behavioral health appointment standards are:

- Member requiring urgent care are seen within two calendar days.
- Appointments for routine office visits are scheduled within two weeks.

Quality measures

Each year the Centers for Medicare and Medicaid Services (CMS) releases a set of quality measures that are used to calculate Star Ratings. CMS uses the quality measures to determine how well a Medicare Advantage Plan and its associated providers are improving the quality, access, and cost of care provided.

Moda Health Plan Inc. and Summit Health Plan Inc. have established a Medicare Stars Committee that provides leadership and directs cross-functional activities and strategic projects to drive Stars, including member education and experience initiatives, HEDIS gap closure, provider engagement outreach, and internal process improvements.

For more information regarding the current Stars Measures please select the current tech notes at this link: Part C and D Performance Data | CMS

Provider reports

Our Analytics Teams send out a reporting package to clinics via the Provider Reports Portal, which can be found at Log in - Moda Health Risk Share Reports. Below is a list of reports that include all members currently enrolled in the Moda Medicare Advantage Plans and Summit Health Medicare Advantage Plans that are assigned to each contracted clinic for primary care.

The purpose of these reports is to help clinical staff at provider organizations identify opportunities to improve care for individual members. Below are a list of these reports and a summary of what data is being included on each.

Report	Description	Use cases	Frequency
Member roster	A complete list of all assigned members for which a VBP applies, plus risk stratification, diagnosis history, recent utilization, assigned PCP, and contact information.	- Identification of members most likely to benefit from PCP outreach - Outreach to high-risk members who utilize the ED and/or are admitted - Connect members to primary care	Monthly
Quality and Care Gap report	Performance rates on all quality measures that are part of VBPs administered by Moda. List of potential care gaps are also included.	- Outreach to members with a care gap - Track clinic performance toward quality bonuses	Monthly

Pharmacy Opportunity report	Specific evidence-based pharmacy management opportunities for all VBP members, such as low medication adherence, low-cost (generic) drug alternatives, polypharmacy, and high-risk opioid prescribing.	- Discuss potential opportunities with patients to:
		  ○ Lower patient expense
		  ○ Increase adherence
		  ○ Reduce opioid risk
		- Manage pharmacy spend to increase shared risk or total cost of care bonus
			Monthly

ER-IP notification report	Frequent updates on any member admitted for an inpatient stay or to a hospital emergency department.	- Follow up with members to ensure continuity of care - Manage ED/IP to increase shared risk or total cost of care bonus	Weekly

If you have any comments or questions or would like additional information on the quality metrics or progress reports, please contact ProviderReports@modahealth.com.

Care Coordination and Case Management

Care coordination and case management services are performed by nurses and behavioral health clinicians with clinical and health plan experience in a wide variety of clinical specialties, acute hospital care, rehabilitation, home health, skilled nursing care and hospice.

On-site, our healthcare services managers and medical directors provide guidance to and oversight of the nurses providing case management services and care coordination.

The nursing staff help coordinate healthcare for our members with acute and chronic medical conditions, serious injuries, or significant ongoing medical needs. They help members and their caregivers navigate the complexities of the healthcare system. They help to coordinate various aspects of members' needs, including medical care, behavioral health, rehabilitation, home health and social services.

Our case managers and care coordination clinicians help meet patients' treatment goals, expedite prior authorizations, and work jointly with health facilities to coordinate discharge plans. In some cases, we may provide telephonic patient follow-up to hospital inpatient admissions.

Referrals to case management

Case management is available to members experiencing serious medical conditions or catastrophic events that require complex coordination for a longer episode of care. Case management is voluntary, with no cost to the member. Case managers can help by working with members and their families as patient advocates to:

- Explain and maximize available benefits
- Communicate with providers
- Ensure discharge plans are in place following an admission
- Contact patients at home to ensure that their medical needs are being addressed
- Connect members with community resources as needed

To make a referral to Case Management, please contact the appropriate Moda Health or Summit Health Healthcare Services team:

Moda Health

Phone: 833-460-0443

Fax: 855-232-6904

Email: casemgmtrefer@modahealth.com

Summit Health

Phone: 833-4460-0444

Fax: 855-232-6904

Email: casemgmtref@yoursummithealth.com

For your convenience, you can access a case management referral form on either provider website at www.modahealth.com or www.yoursummithealth.com.

The following information is needed:

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

Disease Management

Our multidisciplinary clinical team provides individualized health coaching interventions for patients coping with chronic medical conditions. Health coaches help these patients follow their provider's care plans, answering their healthcare questions and empowering them to take charge of their health. Patients in disease management are contacted by our health coaches at regular intervals with the goal of improving patient self-management skills, better preparing patients for their office visits, encouraging provider-patient communication and engaging patients in their provider's care plan.

We notify providers when their patients enroll in one of our disease management programs. Providers are asked if Moda Health, or its affiliate, Summit Health can offer additional assistance with comorbid conditions to help their patients achieve optimal health status. We also provide chart-ready follow-up reports on each patient. If you would like to refer a patient for disease management, please contact us at:

- Moda Health: careprograms@modahealth.com, or by phone at 503-948-5548; toll-free at 877-277-7281.
- Summit Health: careprograms@yoursummithealth.com, or by phone at 833-460-0442.

Coaching is available for the following conditions:

- Cardiac care
- Dental care
- Depression care
- Diabetes care
- Lifestyle coaching
- Respiratory care
- Spine & Joint care
- Women's Health

In addition to offering disease management programs, our healthcare professionals develop and implement targeted, population-based health promotion programs in such areas as:

- Immunizations Health screenings
- Oral health
- Closing gaps in care
- Specialized, condition specific programs

Our goal is to improve the use of preventive healthcare, early diagnosis, and health screening as well as management of chronic illness. Interventions include development of member wellness and self-management materials. We also implement targeted member and provider communications on a wide range of health topics.

Telephone authentication

To protect the privacy of our member information, we require that our customer service representatives authenticate callers inquiring about Member information.

For the physician office, the following information will be requested when a Provider office calls in:

- Caller's first name
- Provider's first and last name or Provider's office/clinic name
- Provider’s tax ID number
- Subscriber ID number
- Member (patient) first name and last name

If the subscriber ID is not known, you will need to provide the Member’s date of birth.

Patient Protection Act

The Patient Protection Act, also known as Senate bill 21, was passed by the 1997 Oregon state legislature to assure, among other things, that patients and providers are informed about their health insurance plans. To that end, we provide this question-and-answer section to outline some important terms and conditions of our plans.

What are a member's rights and responsibilities? Members have the right to:

- Be treated with respect and recognition of their dignity and need for privacy.
- Have access to urgent and emergency services, 24 hours a day, 7 days a week.
- Know what their rights and responsibilities are. Members receive information about their plan, its services, and the practitioners providing care. This information is provided in a way that members can understand.
- Participate with practitioners in decision-making regarding their healthcare. This includes a discussion of appropriate or medically necessary treatment options for their conditions, whether the cost or benefit is covered, and the right to refuse care and to be advised of the medical result of their refusal.
- Receive services covered under their plan.
- Have their medical and personal information remain private. Personal information will be handled in compliance with state and federal law and will be given to third parties only as necessary to administer the plan, as required by law, or as permitted by the member.
- Change to a new primary care practitioner (PCP). Not all plans require members to choose a PCP.
- File a complaint or appeal about any aspect of the plan. Members have a right to a timely response to their complaint or appeal. Members are welcome to make suggestions to the plan.
- Obtain free language assistance services, including verbal interpretation services, when communicating with the plan.
- Have a statement of wishes for treatment, known as an advance directive, on file with their physicians. Members also have the right to file a power of attorney, which allows the member to give someone else the right to make healthcare choices when the member is unable to make these decisions.
- Make suggestions regarding our policy on members' rights and responsibilities.

Members have the responsibility to:

- Read the plan handbook to make sure they understand the plan. Members are advised to call our Medicare Advantage Customer Service with any questions or concerns.
- Choose a PCP quickly for plans that require it.
- Treat all practitioners and their staff with courtesy and respect.
- Supply all the information needed by the plan and practitioners to provide adequate care.
- Understand their health problems and participate in making decisions about their healthcare and forming a treatment plan.
- Follow instructions for care they have agreed to with their practitioner.
- Seek health services from their chosen PCP, unless the plan states otherwise, as in the case of an emergency. Not all plans require members to choose a PCP.

- Use urgent and emergency services appropriately.
- If required by the plan, obtain approval from their primary care practitioner before going to a specialist.
- Present their plan identification card when seeking medical care.
- Notify practitioners of any other health or insurance policies that may provide coverage.
- Reimburse Moda Health and its affiliate, Summit Health from any third-party payments they may receive (not applicable in California).
- Keep appointments and be on time. If this is not possible, members must call ahead to let the practitioner know they will be late or cannot keep their appointment.
- Seek regular health checkups and preventive services.

Members who have any questions about these rights and responsibilities can call the Medicare Advantage Customer Service department.

For plans that require a PCP to coordinate the member's healthcare needs, how will a member know when a referral is needed?

Generally, for plans that require a member to choose a PCP, a referral is needed if the member goes to any provider other than the PCP. If the member goes to a provider without obtaining a referral from the PCP, benefits may be reduced or denied. If the PCP believes the services of another physician or provider of healthcare is needed, usually the PCP will refer the member to a participating provider.

There are exceptions to the referral requirement under a PCP plan. A referral is not needed for emergency medical treatment or for a woman using the services of a participating women's healthcare provider for either a

routine women's exam or for routine pregnancy care. A referral is not needed for chemical dependency or mental health treatment. The member handbook contains more information regarding service authorizations for chemical dependency and mental health.

What does the member do in a medical emergency?

If an individual believes he/she has a medical emergency, the member should call 9-1-1 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room.

If the individual is enrolled in a plan that requires a PCP, and the time required to contact the PCP will place the individual's health in danger, he/she does not need to contact the PCP prior to seeking emergency treatment. However, the individual should contact the PCP as soon as reasonably possible after seeking emergency care. A member is covered anywhere in the world for medical emergency treatment.

The member handbook contains additional information regarding emergency care.

What is Moda Health's position on provider/member communication?

Providers may freely communicate with their patients about available treatment options, including medication treatment options. The final decision to provide or receive services is to be made by the member and provider, regardless of whether Moda Health, its affiliates, or its designated agent has determined such services are medically necessary or covered services.

How will a member know if benefits are changed or terminated?

Each calendar year, Medicare allows us to make changes to the plans that we offer, including costs and benefits, make changes to the Medicare Advantage service area, or choose to stop offering the plan altogether.

We will notify Medicare Advantage members of changes to their health benefit plan through the annual member handbook Evidence of Coverage handbook.

Will a member be informed if his/her PCP is no longer participating in the network?

If a member's PCP ends his or her participation in the network, we will send the member information with instructions on how to select another PCP.

If a member is not satisfied with his/her health plan, how does the member file a grievance or appeal?

A member can file a grievance or appeal by contacting our Moda Medicare Advantage Customer Service department by calling 877-299-9062 toll-free or Summit Medicare Advantage Customer Service department by calling 844-827-2355. The member can also write a letter to:

Moda Health Plan, Inc.

Attn: Moda Health Medicare Appeals

P.O. Box 40384

Portland, OR 97240-0384

OR

Summit Health Plan, Inc.

Attn: Summit Health Medicare Appeals

P.O. Box 820070

Portland, OR 97282

The member handbook section titled "Complaints, Appeals and External Review" contains complete information.

What are your prior authorization and utilization review criteria?

Prior authorization is the process we use to determine whether a service is covered under the plan (including whether it is medically necessary) prior to the service being rendered. Contact our Moda Health Medicare Advantage Customer Service department or Summit Health Medicare Advantage Customer Service department for a list of services that require service authorization. Many types of treatment may be available for certain conditions; the service authorization process helps determine which treatment is covered under the plan.

Obtaining a prior authorization establishes medical necessity but does not guarantee payment. Except in the case of fraud or misrepresentation, prior authorization for medical necessity shall be binding if obtained no more than 30 days prior to the date the service is provided, or five business days from the date of the authorization.

Utilization review is the process of reviewing services after they are rendered to ensure they were medically necessary and appropriate regarding widely accepted standards of good medical practice. For further explanation, see the definition of "medically necessary."

Moda Health and Summit Health medical necessity criteria, along with a description of how they are developed, are available for your review at www.modahealth.com/medical or yoursummithealth.com/provider. You may also request a printed copy of specific criteria by calling Moda Health Medicare Advantage Customer Service at 877-299-9062 or Summit Health Medicare Advantage Customer Service at 844-827-2355.

How are important documents, such as a member's medical records, kept confidential?

We protect a member's information in several ways:

- We have a written policy to protect the confidentiality of health information.
- Only employees who need to access a member's information to perform their job functions are allowed to do so.
- Disclosure outside the company is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law.
- Most documentation is stored securely in electronic files with designated access.
- Paper documentation is scanned electronically and filed into secure file cabinets, only accessible by designated staff.
- Member documentation that is no longer required to be kept on file according to the records retention policy is destroyed in accordance with the destruction policies and procedures.

How can a member participate in the development of our corporate policies and practices?

Member feedback is very important to us. If a member has suggestions for improvements about the plan or our services, we would like to hear from him/her.

We have formed advisory committees — including the Group Advisory Committee for employers and the Quality Council for healthcare professionals — to allow participation in the development of corporate policies and to provide feedback. The committees generally meet two times per year. Please note that committee membership is limited. For more information, a member can call our Healthcare Services team at 800-592-8283 or write us at:

Moda Health Healthcare Services 601 S.W. Second Ave. Portland, OR 97204 www.modahealth.com

How can non-English-speaking members get information about the plan?

Call the Medicare Advantage customer service department toll-free at 877-299-9062 or Medicare Advantage Pharmacy customer service toll-free at 888-786-7509. One of our representatives will coordinate the services of an interpreter over the phone.

What additional information can a member get upon request?

The following documents are available by calling a Medicare Advantage customer service representative:

- A copy of our annual report on complaints and appeals
- A description of our efforts to monitor and improve the quality of health services
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the physicians and providers responsible for a member's care
- Information about our prior authorization and utilization review procedures

Health Insurance Portability and Accountability Act (HIPAA)

Moda Health and its affiliate, Summit Health, as healthcare payers, are subject to HIPAA and HITECH, the federal legislation addressing administrative simplification and the privacy and security of health information. In some ways, HIPAA has not changed how we are able to exchange information with the healthcare professionals providing care for our members. For instance, we are still able to discuss information with your offices regarding billing, eligibility, and benefit questions, provided that the healthcare professional in your office has, in fact, performed the member service that they are inquiring about. However, to better insure against the potential of releasing member information inappropriately, we have implemented consistent practices around items such as caller authentication. You will see references to these privacy- and security-supporting practices in various areas.

We have been very careful to comply with the requirements of HIPAA, HITECH, and the requirements of other federal and state law related to privacy and security of member information. We are also aware that as the law changes or as interpretations of the rules become clearer, we may need to make changes to remain compliant. Should you have any questions regarding HIPAA and/or HITECH compliance, please do not hesitate to contact our Privacy/Security office at 855-425-4192.

Glossary of terms

Agreement A properly executed and legally binding contract between two parties.

Adjudication The steps through which a claim is processed to verify eligibility, determine benefit levels, and establish the amount of reimbursement.

Adjustment A change in the benefit amount on a claim.

Advisory Committee on Practitioner Credentialing Information (ACPCI) Required by Oregon House bill 2144 in May 1999, this committee was created to address practitioner credentialing information.

Ambulatory care medical care provided on an outpatient basis. Ambulatory care is given to persons who are not confined to a hospital.

American National Standard Institute (ANSI) The coordinating organization for America's federated national standards system (standard for transmitting information electronically).

American Society of Anesthesiologists (ASA) Guide the ASA Guide is a billing and coding guide. This publication provides guidelines for reporting anesthesia services and procedures.

Ancillary services Support services provided to a patient during care. They include such services as laboratory and radiology.

Appeal The type of complaint enrollees make when they want Moda Health or its affiliate, Summit Health to reconsider or change a decision that has been made about what services are covered and what Moda Health or its affiliate, Summit Health will pay for a service. For Medicare Advantage members, this includes preservice decisions or limitations.

Applicant A practitioner who is seeking participation on the Moda Health panel.

Assignment The process where a patient requests a third-party payer to forward payment on his or her behalf directly to the physician or other provider of that service.

Audit A formal examination or verification of medical and financial records.

Authorization or authorized services Obtaining approval by Moda Health or its affiliate, Summit Health prior to the date of service for services that have been ordered by the attending physician. Moda Health Medicare Advantage does not require authorization for services.

Average wholesale price (AWP) The standardized cost of a prescription medication that is calculated by averaging the cost of a non-discounted pharmaceutical charged to a pharmacy provider by a large group of pharmaceutical wholesale suppliers.

Benefit package A collection of specific services and treatments a member may receive under the terms of his or her Medicare Advantage organization.

Benefit period for both our Medicare Advantage PPO and original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day a member goes to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when the member has not been an inpatient at any hospital or SNF for 60 days in a row.

Bundling Packaging together costs or services that might otherwise be billed separately. For claims processing, this includes provider billing for healthcare services that have been combined according to industry standards or commonly accepted coding practices.

Call share Coverage arrangements you have made among participating providers to ensure covered services when you are unavailable due to vacation, illness, or patient load. Our Professional Relations department must be notified for documentation unless the claim will be submitted under the same TIN. Call share specialists must be in-network with the patient's plan for the patient to receive the higher level of benefit.

Carrier An insurance company.

Care coordinator Monitors and coordinates the delivery of health services for individual patients to enhance care and manage costs.

Centers for Medicare and Medicaid Services (CMS) CMS is the federal agency that is responsible for the national administration, guidance and instruction of Medicare and Medicaid. Moda Health Plan, Inc., and Summit Health Plan, Inc., contract with CMS to provide Medicare Advantage and prescription medication plans.

Claim form Information submitted by a provider or a covered person that establishes the specific health services provided to a patient. This form can be submitted on paper or electronically.

Clean claim A claim that contains all data and that does not require further investigation.

Clearinghouse An intermediary that accepts electronic transmissions from other organizations, edits, and processes transmissions, then reroutes and sends them electronically to the appropriate payers. In insurance, it is an intermediary that receives claims from healthcare providers or other claimants, edits the claims data for validity and accuracy,

translates the data from a given format into one acceptable to the intended payer, and forwards the processed claim to the appropriate payers.

Clinical editing we employ clinical edits in the processing of medical claims. Our clinical edit set focuses on correct coding methodologies and accurate, appropriate adjudication of claims. The edits have been clinically determined and validated on a code-by-code basis.

CMS 1500 A universal form for providers of services to bill professional fees to health carriers. It is also known as the uniform health insurance claim form. By law, it must be used for claims submitted to the Medicare program by individual healthcare practitioners (formerly HCFA 1500).

Coinsurance A payment members make for their share of the cost of certain covered services they receive. Co-insurance is a percentage of the cost of the service (such as paying 10 percent for a doctor's visit).

Concurrent review Review and assessment of an ongoing inpatient hospitalization to monitor the patient's response to treatment and to assure that hospitalization remains the most appropriate setting to provide the care required by the patient. Promotion of and assistance with continued care and discharge planning are components of this review.

Conversion factor The multiplicative factor applied to the relative value scale to produce a schedule of dollar amounts of payment for providers.

Coordination of benefits (COB) A typical insurance provision whereby responsibility for primary payment for medical services is allocated among carriers when a person is covered by more than one insurance plan.

Copayment A payment members make for their share of the cost of certain covered services they receive. Our Medicare Advantage benefit plans have two types of cost-sharing. The first is a flat fee (i.e., always the same dollar amount for each visit). The second is a percentage of charges, which is sometimes also referred to as "coinsurance." Both types of copayments show in the "Copay" column on your explanation of payment (EOP)). **Please note**: Only the flat fee copayment may be collected on the day services are rendered.

Cost-sharing A general set of financing arrangements via copayments and/or coinsurance where a covered person must pay some of the cost of their healthcare services.

Covered services the medical care, services, supplies and equipment that are covered by our Medicare Advantage agreement and are considered medically necessary services according to Medicare guidelines.

Credentialing The process of determining if a new practitioner can join our Medicare Advantage network. It consists of verifying, through primary sources or NCQA-approved sources, specific elements of the provider's credentialing application that identify the legal authority to practice, relevant training and experience.

Credentialing contacts the person who submitted the application on behalf of the provider.

Current procedural terminology (CPT) The coding system for physicians' services developed by the American Medical Association. It forms the basis of the HCFA common procedural coding system, used to identify specific treatments and services on paper and electronic bills. The five-digit CPT codes are the standard for billing for physician and other professional services.

Custodial care Care that helps a person conduct such common activities as bathing, eating, dressing, or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care also includes care that is primarily for the purpose of separating a patient from others, or for preventing a patient from harming him- or herself.

Date of service (DOS) DOS refers to the date a particular service was performed. The DOS must be the actual date that the services were performed.

Deductible The amount the member must pay for health care or prescriptions before the plan begins to pay.

Delegated entity an IPA, medical group, clinic, third-party panel, or CVO that is delegated the responsibility of credentialing its providers by Moda Health.

Diagnosis code Codes used to classify patient treatment. These codes are required for providers who bill for both inpatient and ambulatory care, as well as itemized billing statements. ICD-10 is also referred to as a diagnosis code.

Diagnostic related groups (DRGs) A federally mandated classification system that uses several hundred major diagnostic categories to assign patients into case types. Using this system, hospital

medical procedures are rated in terms of cost, after which a standard flat rate is set per procedure. Claims for those procedures are paid in that amount, regardless of the cost to the hospital.

Disallowed charges Charges billed that the Medicare Advantage PPO denies. The reason the charge is disallowed is listed on the explanation of benefits (EOB).

Discounted fee-for-service A financial reimbursement process whereby a physician's services are provided to patients based on a rate negotiated with the insurer that is lower than the usual fee the physician charges for the same services.

Disenroll or disenrollment the process of ending membership in Moda Health or its affiliates, Medicare Advantage. Disenrollment can be voluntary or involuntary.

Dual coverage A member who has coverage by more than one insurance plan at the same time. Typically, benefits will be coordinated between the two plans. (See Coordination of benefits).

Effective date the date a contract becomes active.

Electronic data interchange (EDI) The electronic transmission of business data by means of computer-to- computer exchange (either real time or batch).

Electronic remittance advice (ERA) An electronic statement sent to providers that outlines how a payer adjudicated a claim and paid for services. This is the electronic version of an explanation of payment (EOP)

Eligibility The determination of whether an individual has insurance coverage at given point in time.

Eligibility date the defined date a member becomes eligible for benefits under an existing contract.

Emergency care Covered services that are 1) furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Emergency services covered Inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate and stabilize an emergency medical condition.

Encounter data Information describing how a patient was treated during a clinical encounter. Capitated plans do not require a provider to submit a claim; instead, they require submission of encounter data.

Exclusions means the medical care, services, supplies and equipment that are not covered by our Medicare Advantage plans.

Explanation of benefits (EOB) The statement sent to members by their health plan (insurance company or third- party plan administrator) that lists services provided, amount billed, and payment made for a specific treatment and/or charges that were rejected.

Explanation of payment (EOP) A statement sent to providers that outlines how a payer adjudicated a claim and paid for services. A pay may use an electronic remittance advice (ERA) to advise providers.

Federal register A publication that makes available to the public proposed and final government rules, legal notices, orders, and documents having general applicability and legal effect. It contains published material from all federal agencies.

Fee-for-service (FFS) Patient fees are charged based on a rate schedule established for each service and/or procedure provided. The medical provider receives payment for each covered service delivered.

Fee schedule A list of codes and related services with pre-established payment amounts, which could be percentages of billed charges, flat rates, or maximum allowable amounts.

Follow-up days (FUD) FUD are the visits for follow-up care rendered during a normal surgical recovery that are included in the fee for the surgical service.

Grievance A complaint that members make if they have any type of problem not defined as an appeal with Moda Health Plan, Inc., its affiliates, or one of our plan providers. An example of a grievance is when a member complains about not getting information they need.

Health Care Financing Administration (HCFA) See Centers for Medicare and Medicaid Services (CMS).

Health Insurance Portability and Accountability Act of 1996 (HIPAA) A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives the Department of Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of healthcare data; to specify what medical and administrative code sets must be used within those standards; to require the use of national identification systems for healthcare patients, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable healthcare information.

Healthcare Common Procedure Coding System (HCPCS) The Healthcare Common Procedure Coding System (HCPCS) consists of standardized code sets that are necessary for the consistency and management of provider healthcare claims. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Home health Medical care services provided by a visiting nurse in the home of patients who need skilled care.

Homebound When a patient is unable to leave home, and leaving home is a major effort. When a patient leaves home, it must be to get medical treatment or be infrequent and for a short time.

Hospice A program that provides palliative and supportive care for terminally ill patients and their families during the last months of life.

Hospital affiliation A contractual relationship between Moda Health Medicare Advantage and one or more hospitals where the hospital provides inpatient care/services covered by Moda Health Medicare Advantage.

Incidental A medical service or procedure is considered incidental if its performance generally requires relatively little additional time or effort compared to the major procedure with which it is associated.

Independent physician association (IPA) A healthcare model that contracts with an entity, which in turn contracts with physicians, to provide healthcare services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per-capita fee schedule or a fee-for-service basis.

In-network When a member receives medical care using a provider in the specified network that is assigned to their medical plan.

In-network provider "Provider" is the general term we use for doctors, other health care professionals, hospitals and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We refer to them as "in-network providers" when they are contracted as Moda Health Medicare Advantage providers. When we say that in-network providers are "part of Moda Health Medicare Advantage," this means that we have arranged with them to coordinate or provide covered services to members of Moda Health Medicare Advantage. Moda Health pays in-network providers based on the contracts it has with the providers.

International Classification of Diseases, 10th Revision (ICD-10CM) Codes used to classify patient treatment. These codes are required for providers who bill for both inpatient and ambulatory care, as well as itemized billing statements. ICD-10 is also referred to as a diagnosis code.

Lock-in All medical claims must be submitted to Moda Health Medicare Advantage for processing. Claims for services while a member is enrolled in Moda Health Medicare Advantage should not be submitted to original Medicare.

Medically necessary Services and supplies that are proper and needed for the diagnosis or treatment of a member's medical condition; are used for the diagnosis, direct care, and treatment of a member's medical condition; meet the standards of good medical practice in the local community and are not mainly for the convenience of the member of the member's doctor.

Medicare Advantage organization A public or private entity organized and licensed by a state as a risk-bearing entity (except for provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.

Medicare Advantage plan A benefit package offered by a Medicare Advantage organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the plan. A Medicare Advantage organization may offer more than one plan in the same service area.

Member A person with Medicare who is eligible to get covered services, who has enrolled in one of our Medicare Advantage plans, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services A department within our company responsible for answering member questions about membership, benefits, and grievances and appeals.

Moda Health refers to Moda Health Plan, Inc.

Modifiers Codes used to supplement CPT or HCPCS codes that permit payment to differ for a subset of services billed. They may indicate that the service has been changed in some way.

National Committee for Quality Assurance (NCQA) A private, not-for-profit organization that is active in quality oversight and improvement initiatives at all levels of the healthcare system. It assesses and reports on the quality of the nation's managed care plans through accreditation and performance measurement programs.

Network A system of contracted physicians, hospitals and ancillary providers that provides healthcare to members.

Organization determination is an approval, or a denial made by Moda Health, or its affiliates, regarding specific services, as defined by CMS. We must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a determination. An expedited organization determination may be requested by a member or any physician when:

The member or his/her physician believes that waiting for a decision under the standard time frame would place the enrollee's life, health, or ability to regain maximum function in serious jeopardy; and

The member believes Moda Health should furnish a directory or arrange for services to be provided (when the enrollee has not already received the services outside Moda Health).

Oregon provider credentialing application (OPCA) A statewide application created by the ACPCI that may be used by Oregon hospitals and health plans for credentialing.

Oregon practitioner re-credentialing application (OPRA) A statewide application created by the ACPCI that may be used by Oregon hospitals and health plans for re-credentialing.

Original Medicare A plan that is available everywhere in the United States. Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets members go to any doctor, hospital or other health care provider who accepts Medicare. Members must pay their deductible. Medicare pays its share of the Medicare-approved amount, and members pay their share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare services must be medically necessary.

Outlier With a per- case reimbursement system (DRG), a claim where charges or length of stay exceeds an established threshold and additional payment is made.

Out-of-network (OON) When a member receives medical care using a provider not in our Medicare Advantage network. Generally, the member will pay a higher cost for services when they receive care out of network

Out-of-network provider or out-of-network facility A provider or facility that we have not arranged with to coordinate or provide covered services to our members. Out- of- network providers are providers that are not employed, owned, or operated by Moda Health Medicare Advantage and are not under contract to deliver covered services to our members.

Out-of-pocket (OOP) The amount a member pays toward copays and coinsurance. Optional supplement expenses do not accumulate to a plan's out-of-pocket maximum.

Part A [Medicare] The hospital insurance program that covers the cost of hospital and related post-hospital services. As an entitlement program, it is available without payment of a premium to most individuals when they turn age 65 or are deemed disabled by the Social Security Administration. Individuals not eligible for Social Security or Railroad Retirement Board may have to pay a premium for Part A benefits.

Part B [Medicare] The supplementary medical insurance program (SMI) that helps pay for services other than hospital [Part A] services. As a voluntary program, Part B requires payment of a monthly premium.

Patient responsibility the amount the patient is responsible to pay for the services received. This amount includes charges denied as not a covered service, copayments, and coinsurance.

Plan The benefits and services the member has under Moda Health, and its affiliate, Summit Health Medicare Advantage.

Plan of care describes the services a patient needs, how often they are needed and what type of healthcare worker should give the services.

Pre-Authorization or Prior Authorization Approval in advance to get services. Please refer to the members handbook.

Professional component the part of a relative value or fee that represents the cost of the physician's interpretation of a diagnostic test or treatment planning for a therapeutic procedure.

Provider Relations (PR) A department of Moda Health and its affiliates, that is responsible for contracting medical providers and maintaining our provider panel and directories.

Provider An individual or facility, licensed in the state in which he/she or it practices, providing covered diagnostic, medical, surgical or hospital services and performing within the scope of that license.

Provider directory A listing of all the providers and facilities that are contracted in our Medicare Advantage network.

Provider discount the amount of money a member saves on a service by using a contracted provider.

Participating provider administrative manual the manual containing information and instructions for providers, which is prepared by Moda Health and its affiliates, and may be revised from time to time.

Quality improvement organization (QIO) A group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They must review member complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private fee-for-service plans, and ambulatory surgical centers. There is one QIO in each state. In Oregon, the QIO is called OMPRO.

Re-credentialing the process completed every three years for the purpose of determining a provider's continuing participation on our provider panel. It consists of verifying, through primary sources or NCQA-approved sources, specific elements of the provider's re-credentialing application, member complaints, potential and confirmed adverse outcomes, access and after-hours availability, medical record audits and site visits.

Referral When a provider requests that the member receive care from a different physician or facility. Summit Health HMO plans require referrals for services.

Relative value unit (RVU) A unit of measurement used by the federal government that establishes the value of each service, known as a CPT Code. RVUs must be multiplied by a dollar conversion factor to become payment amounts.

Resource-based relative value scale (RBRVS) A fee schedule introduced by HCFA to reimburse providers' Medicare fees based on the amount of time and resources expended in treating patients, with adjustments for overhead costs and geographical differences.

Service area the geographic area approved by CMS within which an eligible individual may enroll in a particular plan offered by a Medicare health plan.

Service authorization Obtaining approval from Moda Health and its affiliate, Summit Health prior to the date of service for services that have been ordered by the attending provider.

Technical component (TC) The part of the relative value or fee for a procedure that represents the cost of doing the procedure, excluding physician work.

Third-party liability (TPL) A situation where another person or company may be responsible or liable for an injury that caused the medical expenses incurred by the insured person.

Third-party payer A public or private organization that pays for or underwrites coverage for healthcare expenses for another entity, usually an employer.

Unbundled charges Coding and billing separately for procedures that do not warrant separate identification because they are inherently a part of another service or procedure.

Up-coding Coding and billing for a service that is worth more when a lesser service has been provided and/or documented.

Urgently needed services Covered services that are not emergency services as defined in this section, provided when a member is temporarily absent from the service area (or, if applicable, continuation) when the services are medically necessary and immediately required.

Utilization review the process of a third party reviewing medical treatment, either before or after care is administered, to ensure the treatment was or is appropriate for the patient's condition. This review is performed either by the internal staff of an insurance company or provider, or by a third-party organization that is retained for that purpose. It is designed to reduce the overall cost of care by detecting unnecessary treatment.

Acronyms

AC	Acupuncturist
ACPCI	Advisory committee on practitioner credentialing information
ALOS	Average length of stay
ANP	Adult nurse practitioner
ANSI	American National Standard Institute
ARNP	Advanced registered nurse practitioner
ASA	American Society of Anesthesiologists
ASC	Ambulatory surgical center
ASO	Administrative services only
AuD	Audiology doctorate
AWP	Average wholesale price
BA	Bachelor of Arts degree
BS	Bachelor of Science degree
BSN	Bachelor of Science nursing
CA, CAc	Certified acupuncturist
CAMT	Certified acupressure massage therapist
CDE	Certified diabetes educator
CF	Conversion factor
CHt	Clinical hypnotherapist
CLIA	Clinical laboratory improvement amendments
CMS	Centers for Medicare and Medicaid Services
CMT	Certified massage therapist
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT	Current procedural terminology
CRNA	Certified registered nurse anesthetist
CRT	Certified respiratory therapist
CSN	Certified school nurse
CST	Certified surgical technologist
CWS	Certified wound specialist
DC	Doctor of Chiropractic
DDS	Doctor of Dental Surgery
DHHS	Department of Health and Human Services
DMD	Doctor of Medical Dentistry
DME	Durable medical equipment
DO	Doctor of Osteopathy
DOB	Date of birth
DOS	Date of service
DPM	Doctor of Podiatric Medicine

DRG	Diagnosis-related group
DTR	Dietetic technician registered
DX	Diagnosis code
EAP	Employee assistance program
EdD	Degree in education
EDI	Electronic data interchange
EMT	Emergency medical technician
EOB	Explanation of benefits
EOP	Explanation of payment
ER	Emergency room
ERISA	Employee Retirement Income Security Act of 1974
FCHN	First Choice Health network
FFS	Fee for service
FNP	Family nurse practitioner
FUD	Follow-up days
GNP	Geriatric nurse practitioner
HCFA	Healthcare Financing Administration — see CMS
HCPCS	Healthcare Common Procedural Coding System
HEDIS	Health Plan Employer Data Information Set
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD-9-CM	International Classification of Diseases, 9th Edition
ICD-10-CM	International Classification of Diseases, 10th Edition
ICF	Intermediate care facility
INF	Infertility
IPA	Independent practice association
IPN	Idaho Physicians Network
LAc	Licensed acupuncturist
LCSW	Licensed clinical social worker
LLP	Limited licensed practitioner
LMFT	Licensed marriage & family therapist
LMP	Licensed massage practitioner
LMT	Licensed massage therapist
LN/LNC	Licensed nutritionist/counselor
LPC	Licensed professional counselor
LPN	Licensed practical nurse
LPT	Licensed physical therapist
LSW	Licensed social worker
MA	Master of Arts
MAc	Masters in Acupuncture
MD	Medical doctor
MFCC	Marriage, family, and child counselor
MFT	Marriage and family therapist
MH	Master herbalist

MHNP	Mental health nurse practitioner
MMA	Mountain Medical Affiliates
MPA	Maximum plan allowance
MS	Master of Science
MSN	Master of Nursing
MSW	Master of Social Work
NANP	Not accepting new patients
NCQA	National Committee for Quality Assurance
ND	Naturopathic doctor
Non-Par	Non-participating
NP	Nurse practitioner
OD	Doctor of Optometry, optometrist
Moda Health	Multi-faceted organization with a full line of affordable health plans
OOA	Out of area
OON	Out of network
OOP	Out of pocket (costs)
OPA	Orthopedic physician's assistant
OPCA	Oregon practitioner credentialing application
OPRA	Oregon practitioner re-credentialing application
OT	Occupational therapy
OTC	Over the counter (drug)
PA	Physician assistant/psychologist assistant
PACE	Program of all-inclusive care for the elderly
Par	Participating
PCP	Primary care physician
PCPM	Per contract per month
PEPM	Per employee per month
PHCS	Private health care systems
PhD	Doctor of Philosophy
PMHNP	Psychiatric mental health nurse practitioner
PMPM	Per member per month
PNP	Pediatric nurse practitioner
POS	Place of service/point of service
PPO	Preferred provider organization
PR	Professional Relations
PSYA	Psychology associate
PsyD	Doctor of Psychology
PT	Physical therapy
PTA	Physical therapist assistant
QA	Quality assurance
QCSW	Qualified clinical social worker
QI	Quality improvement
RAc	Registered acupuncturist
RBRVS	Resource-based relative value scale

RCSW	Registered clinical social worker
RD	Registered dietitian
RDN	Registered dietitian and nutritionist
RN	Registered nurse
RN/NP	Registered nurse, nurse practitioner
RNFA	Registered nurse first assistant
RNSA	Registered nurse surgical assistant
RPh	Registered pharmacist
RRT	Registered respiratory therapist
RVU	Relative value unit
SLP.D	Doctors in Speech-Language Pathology
SMI	Supplementary medical insurance
SNF	Skilled nursing facility
SVC	Service
TAT	Turnaround time
TIN	Tax Identification number
TOS	Type of service
TPA	Third-party administrator
TPL	Third-party liability
VBP	Value-based product
YTD	Year to date