2020 Provider Workshop

Presented by Moda Health

Welcome

Primary Care

Agenda

- PCP Requirements
- Claims
- Prior Authorizations / Referrals
- Healthcare Services
- Commercial Networks
- Value Based Care
- Reconsiderations and appeals
- Benefit Changes
- Medicare Advantage

PCP Requirements

- Licensed –
  - MD, DO, NP, PA
- Specialty -
  - Family practice
  - Internal medicine
  - Obstetrics/gynecology
  - Pediatrics
  - Geriatrics
- Provide services within their scope of practice as defined by law and state licensure
- Hospital admitting privileges or arrangements
- Authority to prescribe medication

PCP Requirements - continued

- 24/7 PCP call coverage
- Completed 3-year Residency at an accredited program
- Participate in medical record audits
- Participate in office site visit
- Complete access and after-hours surveys
- Credentialed
- Contracted

PCP Requirements - continued

Moda Health 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.

Call Share

- PCP Providers
  - Same Tax ID Number
  - Same Network
  - PCP provider type

New Patient vs Established

- When 99211-99215 (Established Patient) codes are reported for a new patient member (with no previous billed services within the past 3 years), a clinical edit denial will be generated.
- Established patient-previous services occurred before the member became effective on the Moda plan
- Providers with a different specialty or subspecialty than another provider (same group) that has previously seen a patient, the specialist can bill a New Patient visit.

Preventive Care vs Medical

- Preventive services mandated in the Patient Protection and Affordable Care Act (PPACA) at 100% when the member is seeing an in-network provider.
- Moda Health also covers a limited list of additional tests when billed with a routine, preventive, or screening diagnosis code.

Policy-

Preventive Services versus Diagnostic and/or Medical Services

modahealth.com/pdfs/reimburse/RPM037.pdf

Preventive Care vs Medical - continued

- Medical E/M visit Combined with a Preventive E/M Visit
  - CPT guidelines define the documentation and coding requirements for reporting an additional problem-oriented E/M service in combination with the preventive E/M service code.
- Lab tests ordered at an annual preventive health visit (99381 – 99397) are not all automatically eligible for coverage no-cost-share Affordable Care Act preventive benefit
- Diagnosis codes must point to the correct procedure codes

Incident to Services

- Commercial Plans
  - Moda Health does not recognize or allow incident-to billing for Moda Health Commercial plans. Practitioners must bill under their own name and provider identification (NPI, TIN)

- Medicare Advantage Plans
  - Moda Health follows CMS Incident-to billing rules for our Medicare Advantage plans.

  modahealth.com/pdfs/reimburse/RPM040.pdf

Benefit Tracker

- Access BT from two platforms-
  - ModaHealth – modahealth.com/medical/mbt.shtml
  - OneHealthPort - onehealthport.com/sso
- Access to detailed patient benefit information
- Moda Website contains additional information that OneHealthPort may not capture
- Login required for each site
- Information and questions email - ebt@modahealth.com

Claims

Claims

New remittance design

- Explanation of Payment (EOP) to highlight info pertinent to the provider
  - Previously known as Payment Disbursement Register (PDR)
- Access to EOP copies through Benefit Tracker
  - Non-contracted providers must request copies through Moda Customer Service

Claims

Corrected claims

- CMS-1500 (Professional)
  - Box 22 of the claim form should have resubmission code 6 (corrected), code 7 (replacement) or code 8 (Void/cancel)
  - Indicate “corrected claim” in box 19
- UB-04 (Facility)
  - Bill Type XX7 (in field 4) indicates a replacement of prior claim or corrected claim
- Address for corrected claim submission:

  P.O. Box 40384

  Portland, OR 97240

Telehealth – Temporary COVID-19

- Moda's website has the most up-to-date reimbursement policy for telehealth/telemedicine
  - Expanded telehealth policy valid during the Public Health Emergency (PHE) modahealth.com/pdfs/reimburse/RPM073_COVID-19TelehealthExpansion.pdf
  - Original telehealth policy modahealth.com/pdfs/reimburse/RPM052_TelehealthTelemedicine.pdf
- Expanded telehealth policy valid until 12/31/2020 for commercial plans (subject to change)
- Medicare Advantage plans – until directed by CMS that the temporary expanded coverage has ended

Claims

Clinical edits – Clinical Editing Systems

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

modahealth.com/pdfs/reimburse/RPM002.pdf

Claims

Clinical Edits – Medicare Advantage LCD/NCD Edits

- CMS documents a wealth of very specific coding and coverage requirements
- National Coverage Determinations (NCDs),
- Local Coverage Determinations(LCDs, e.g. Noridian LCDs), transmittals, MLN articles, and other sources

modahealth.com/pdfs/LCD_NCD_edit_FAQ.pdf

Claims

National Correct Coding Initiative (NCCI) links

- MUE information: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE
- PTP coding edit information: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits
- NCCI FAQ: cms.gov/medicare/national-correct-coding-initiative-edits/ncci-faqs

Prior Authorizations / Referrals

Prior Authorizations/Referrals

- How to determine that a service requires prior authorization
  - Review Referral and Authorization guidelines based on line of business
  - Review “Always Not covered” list
  - Access Prior Authorization forms

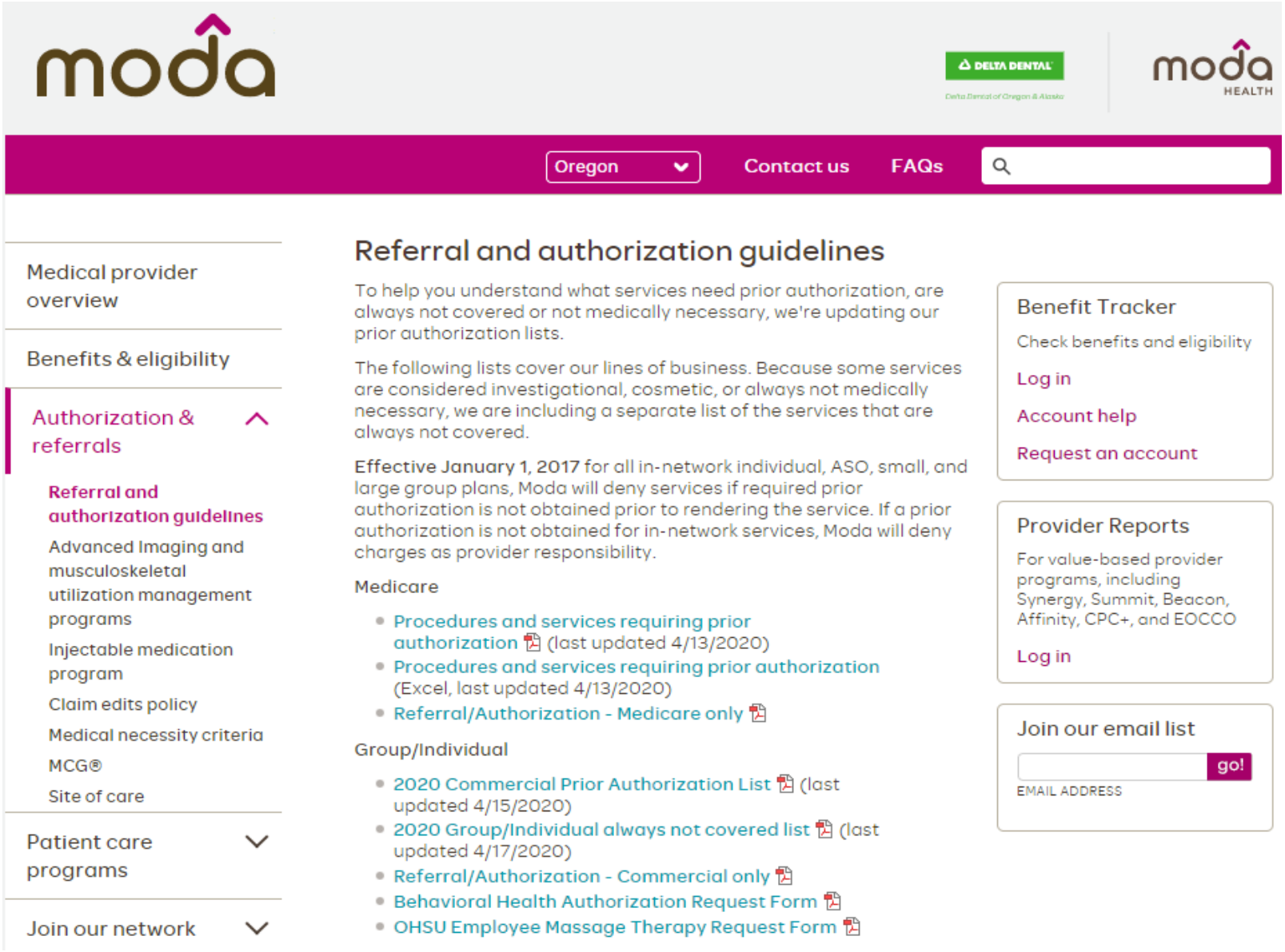
  modahealth.com/medical/referrals/

- Failure to obtain prior authorization when required may result in claim denial. Members can not be balance billed.
  - Note: Prior Authorizations are not required when Moda Health is not the primary payer.

Prior Authorizations/Referrals

- Commercial
  - Referrals are not required for members to see a participating specialist
  - Prior authorizations are required for non-par providers.
  - Linn County is the only commercial plan with referral requirements
- Medicare Advantage
  - HMO plans require referral from PCP to specialists
- Providers are encouraged to refer to Moda Health participating providers in the members' assigned network(s).
  - Some plans have no out of network benefits
  - Refer to Find Care for participating providers

modahealth.com/medical/referrals/



Healthcare Services

Healthcare Services

eviCore

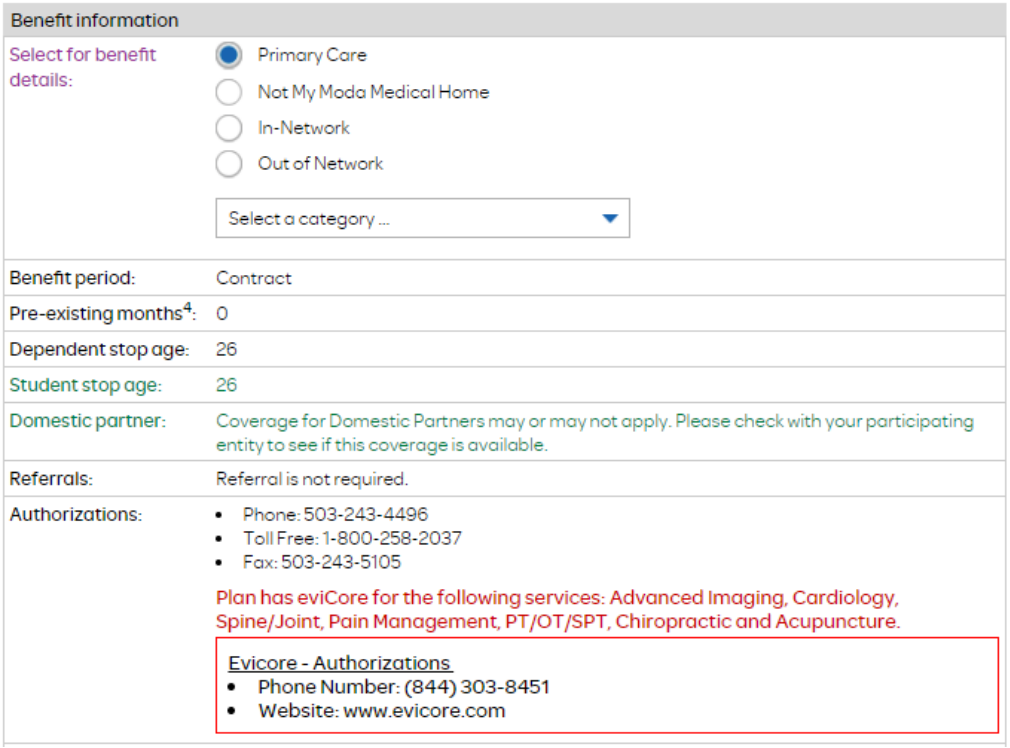
- eviCore reviews authorization requests for the following services:
  - Advanced Imaging
  - Musculoskeletal therapies
  - Pain management
  - Spine and joint surgery
- Services that require prior authorization through eviCore are listed on our website:

  modahealth.com/medical/utilizationmanagement.shtml

Healthcare Services

eviCore

- Check Benefit Tracker to determine if member's plan utilizes eviCore and for what services
  - Can be found on main benefit page in red



Benefit information	
Select for benefit details:	◉ Primary Care ○ Not My Moda Medical Home ○ In-Network ○ Out of Network Select a category ...
Benefit period:	Contract
Pre-existing months[4]:	0
Dependent stop age:	26
Student stop age:	26
Domestic partner:	Coverage for Domestic Partners may or may not apply. Please check with your participating entity to see if this coverage is available.
Referrals:	Referral is not required.
Authorizations:	• Phone: 503-243-4496 • Toll Free: 1-800-258-2037 • Fax: 503-243-5105 Plan has eviCore for the following services: Advanced Imaging, Cardiology, Spine/Joint, Pain Management, PT/OT/SPT, Chiropractic and Acupuncture. Evicore - Authorizations • Phone Number: (844) 303-8451 • Website: www.evicore.com

Clinical Guidelines

eviCore

- eviCore has clinical worksheets and guidelines available to assist you with submission of authorizations online
- The clinical guidelines provide prerequisites required before a service will be authorized, e.g. needing to try physical therapy before having surgery

Clinical Guidelines

eviCore

Provider's Hub

- Clinical guidelines/worksheets can be accessed *before* logging in to the portal
- Resources
  - Training Resources
  - Video tutorials
  - How to's

evicore.com/provider

Clinical Guidelines

eviCore

Authorization Denials

- Peer to Peer consultation
  - Can be requested through the provider portal evicore.com/-/media/files/evicore/provider/training-resources/consultation-guide.pdf
- Formal appeal
  - Process outlined on denial letter for members and providers modahealth.com/pdfs/evicore_member_denial.pdf

Healthcare Services

Magellan Rx

- Provider-administered injectable drug program
  - Prior authorization required for specific injectable specialty medications

  modahealth.com/medical/injectables/
- Site of Care program
  - Certain provider-administered drugs only authorized in outpatient setting or patients home

  modahealth.com/medical/siteofcare.shtml
- Claim edits program

Healthcare Services

Magellan Rx

- Moda Health Contracted providers have access to an online Magellan account.
  - Visit the self-service provider portal at magellanrx.com/provider/landing
  - Click on New Access Request-Provider under Quick Links
  - Click on Contact Us to register
- Urgent or expedited request call 800-424-8114

Healthcare Services

CoverMyMeds

- Partnership with CoverMyMeds to process electronic Prior Authorization (ePA) requests for medications covered under a member's pharmacy benefit
- This free online tool is integrated with all health plans and most large EHR systems
- This does not replace Magellan Rx for injectable medications or Ardon Health for specialty pharmacy

covermymeds.com

Healthcare Services

Infused specialty medications

The following specialty medications will only be available under the pharmacy benefit

Type	Brand Name	Procedure Code
Respiratory/Dermatology	Cinqair	J2786
Respiratory/Dermatology	Fasenra	J0517
Respiratory/Dermatology	Xolair	J2357
Respiratory/Dermatology	Nucala	J2182
Multiple Sclerosis	Ocrevus	J2350

Healthcare Services

The Collective Platform

Why the Importance?

Improve health outcomes

- High-risk/need members
- Closing care gaps

Consumer and staff experience

- Building lasting relationships

System efficiency

- Reducing Duplication of services (post ED visit calls)
- Improve communication gaps between facilities

Healthcare Services

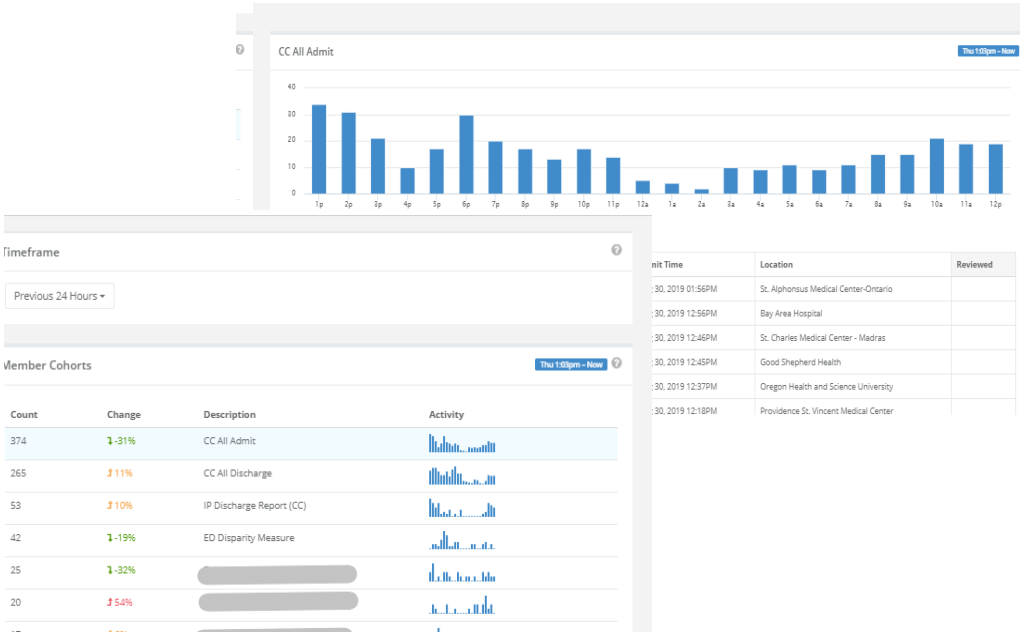
The Collective Platform

A shared communication tool sending real-time notification alerts from ED admits directly to your EHR

Users can contribute critical information about high-risk patients to assist ED providers in patient care and treatment.

Benefits:

- Faster engagement to care
- Access to necessary information in one system
- Ability to provide care recommendations
- Monitor specific populations within your clinic



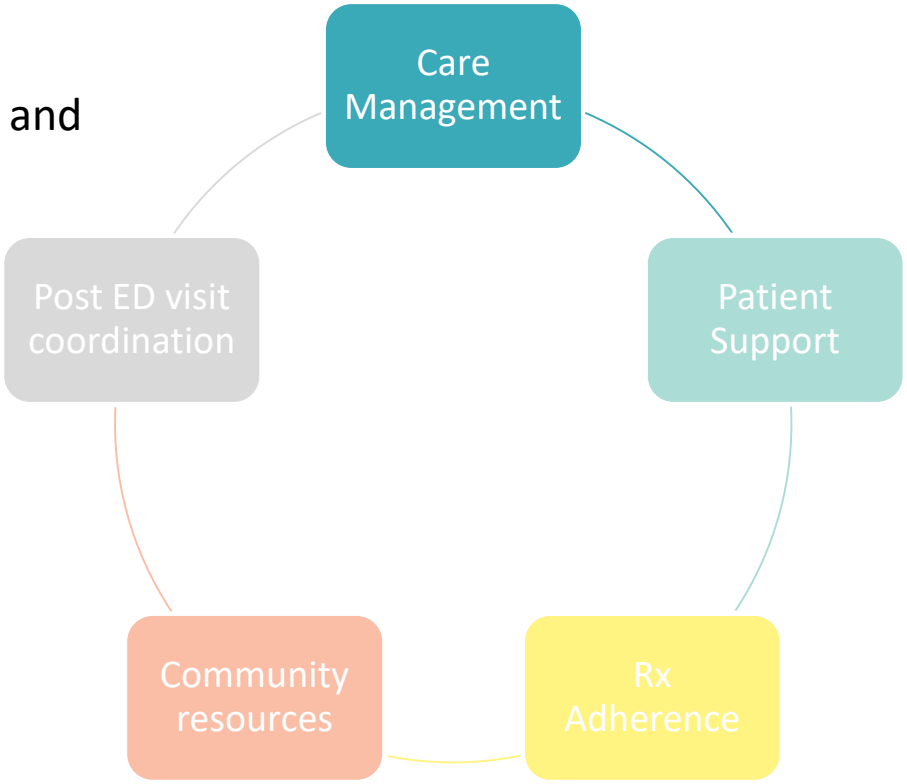
Healthcare Services

The Collective Platform

Identifying patient populations for collaborative care

Build out shared and agreed upon roles and responsibilities of the Care Coordinated workflow(s) between facility and Moda

Maintain communication through regular ongoing meetings



moda

Healthcare Services

The Collective Platform

Single sign on integration

Ability to implement single sign on platform so you don't have to worry about logging in every time

Reports

Ability to generate reports on your patients ED activity

Global Flags

Ability to see "global flags" created by other facilities who are on the Collective Platform. Some examples:

- Members transitioning across CCOs
- Members transitioning across CCOs and have a care plan attached
- Risk stratification
- Program eligibility
- COVID lab results (positive, pending, negative) from hospital
- History of Sepsis

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Healthcare Services

The Collective Platform

Not ready to fully commit?

Because of COVID-19, Collective is offering **free access** to users who are not on the Collective Platform to monitor their patient population on COVID-19 related encounters.

Cohorts available to use in tracking your patients include:

COVID-19 Chief Compliant	COVID-19 Symptomatic encounters	COVID-19 Working Dx

moda

Healthcare Services

The Collective Platform

Questions and/or interested in collaborating in care coordination

Contact ***Michaela Nichols*** *at*

PreManageInquiry@modahealth.com

HEDIS

HEDIS

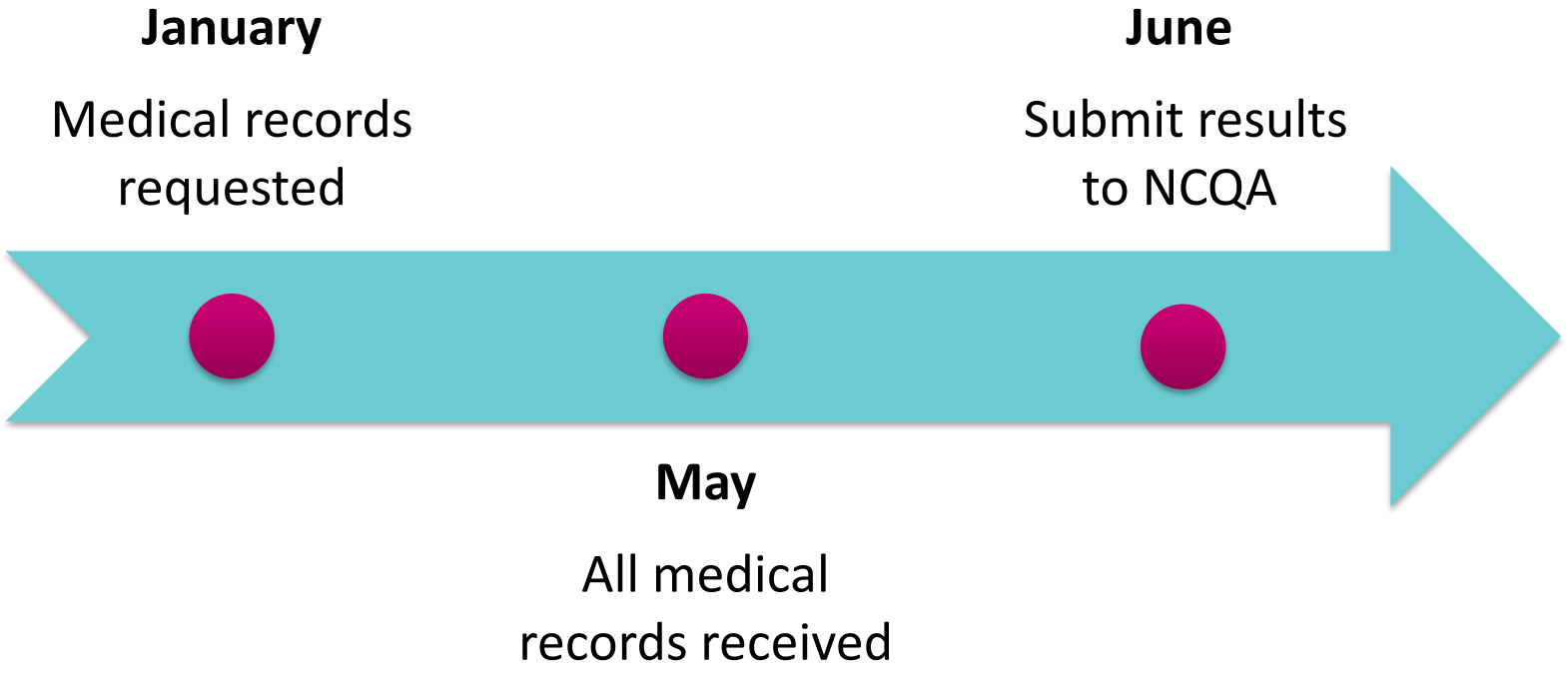
- HEDIS = **Health Effectiveness Data Information Set**
  - Standardized set of metrics created by NCQA that evaluates clinical quality
  - NCQA accreditation is considered an important indicator of a plan's ability to improve health
- Cotiviti will be the chart retrieval vendor for 2021
  - Fax requests
  - Onsite retrievals
- KDJ Consultants, Inc. will perform the remote EHR retrievals

Moda's Remote EMR Access program for HEDIS medical record retrieval

- Our long-standing partners, KDJ Consultants, will work with you to establish remote EMR access
- During HEDIS season, KDJ Consultants will retrieve the required EMR information directly – freeing up your clinic's valuable resources & time
- Remote EMR access is safe, secure, HIPAA compliant & HITRUST certified
- For questions or to sign-up for our Remote EMR Access program, please contact - **HEDIS@modahealth.com**

HEDIS

Production timeline



Commercial networks

2021 Commercial networks

2021 Commercial Networks -Group

Connexus

- State wide PPO plan
- PCP selection, referrals not required

Synergy

- Coordinated care plan for employer groups offered statewide

2021 Commercial Networks - Group

OHSU PPO	• OHSU employee plan. • Tiered benefits • Provider participation determined by OHSU
OHSU EPO	• OHSU employee plan. • Tiered benefits; no out of network coverage. • Provider participation determined by OHSU.
OHSU Tuality Health & Assoc.	• Tuality Hospital employee plan. • Provider participation determined by Tuality.
CCN	Tier 2 benefit plan for OHSU PPO and OHSU EPO

2021 Commercial Networks - Individual

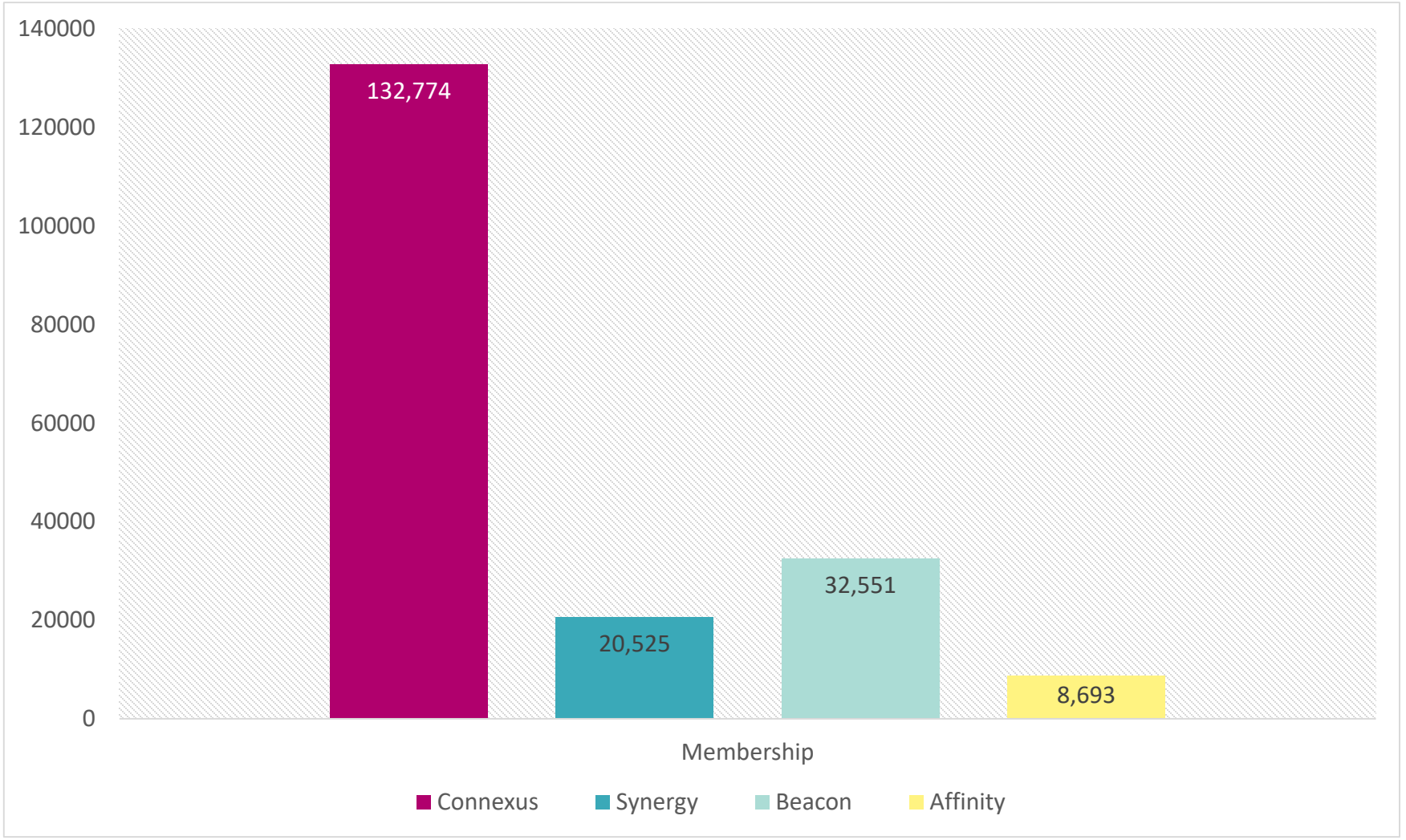
Beacon

- Individual Exclusive Provider Organization plan sold in/out of the Exchange
- Available in 13 counties

Affinity

- Individual Exclusive Provider Organization plan sold in/out of the Exchange
- Available in 18 counties.

Commercial Membership



Commercial PPO networks

Connexus

Small and Large Group plans

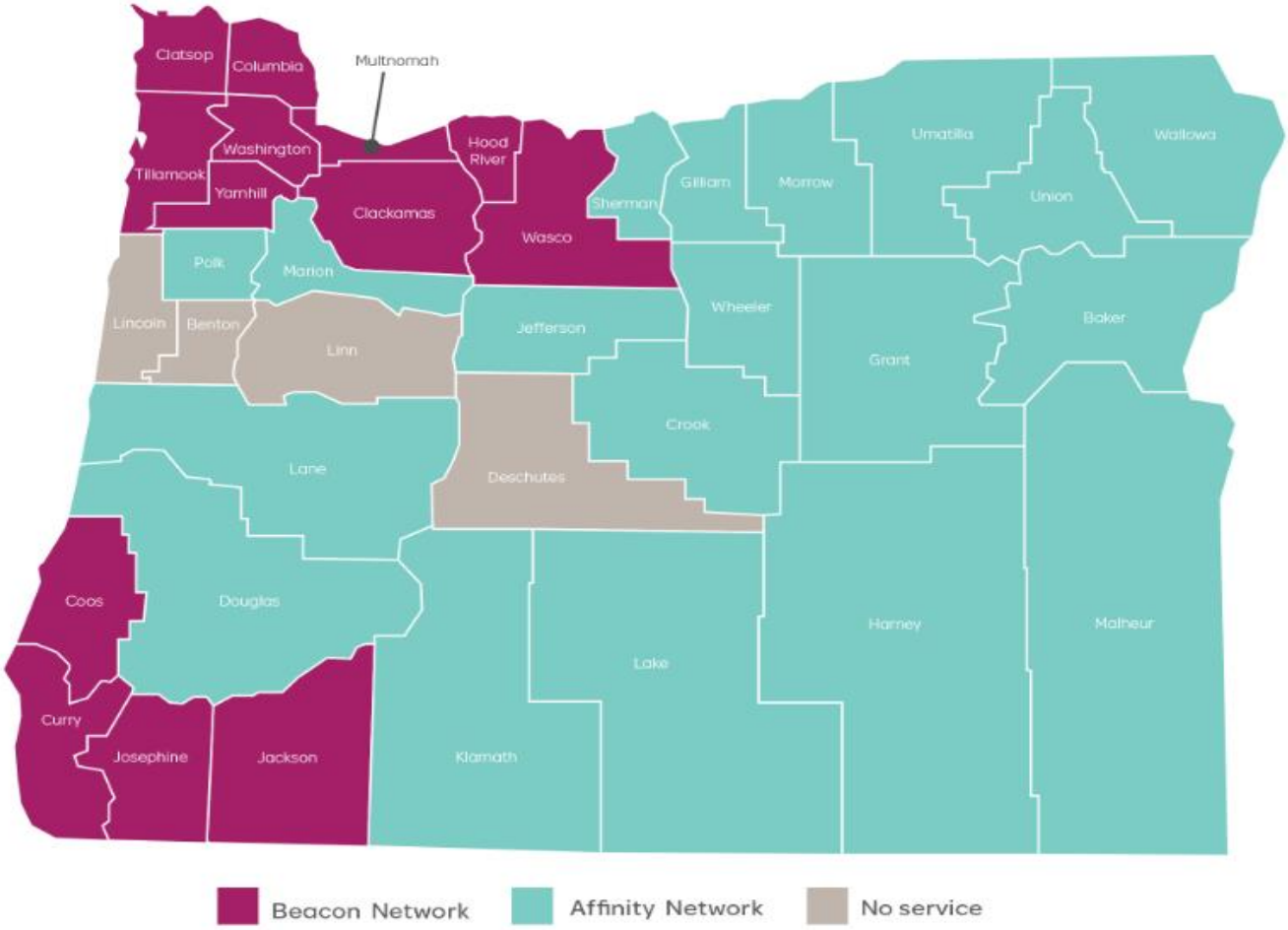
- Connexus
  - Statewide PPO network
  - No PCP/Medical Home selection required
  - No referrals required
  - Member can see in-network providers in all counties in Oregon, and some areas of Washington and Idaho

OHSU and CCN networks

- OHSU PPO
  - Tier 1 benefit plan for OHSU employees only with statewide participation determined by OHSU (closed panel)
- OHSU EPO
  - New OHSU employee plan (closed panel)
- OHSU Tuality Health and Associates
  - Tuality employee plan (closed panel)
- CCN
  - Tier 2 benefit plan for OHSU employees only with participation determined by OHSU (closed panel)

Individual Networks

Individual Network Service Area



Beacon Network

- What is the Beacon Network?
  - Clinically integrated network, which includes 10 health system partners and their referring providers
  - PCP selection is required
  - Exclusive Provider Organization (EPO)
  - No longer available in Marion and Polk County in 2021

Affinity Network

What is the Affinity Network?

- Clinically integrated network, which includes 15 health system partners and their referring providers
- PCP selection is required
- Available in Marion and Polk County in 2021
- Exiting Deschutes County in 2021
- Exclusive Provider Organization (EPO)

Value-based Care Networks

Synergy Network

- Statewide network
- No referrals required
- Small group Synergy members need to pick a PCP
  - PEBB Synergy members will need to pick a “PCP 360”

Value-based care

Primary care assignment

- Value-based care plans require selection of a PCP assignment for each covered individual
  - Each family member makes their own selection
- Must use selected primary care physician for primary care services in order to receive enhanced benefits
- Primary care received ***outside*** of your assigned PCP will be processed and paid as ***out-of-network***

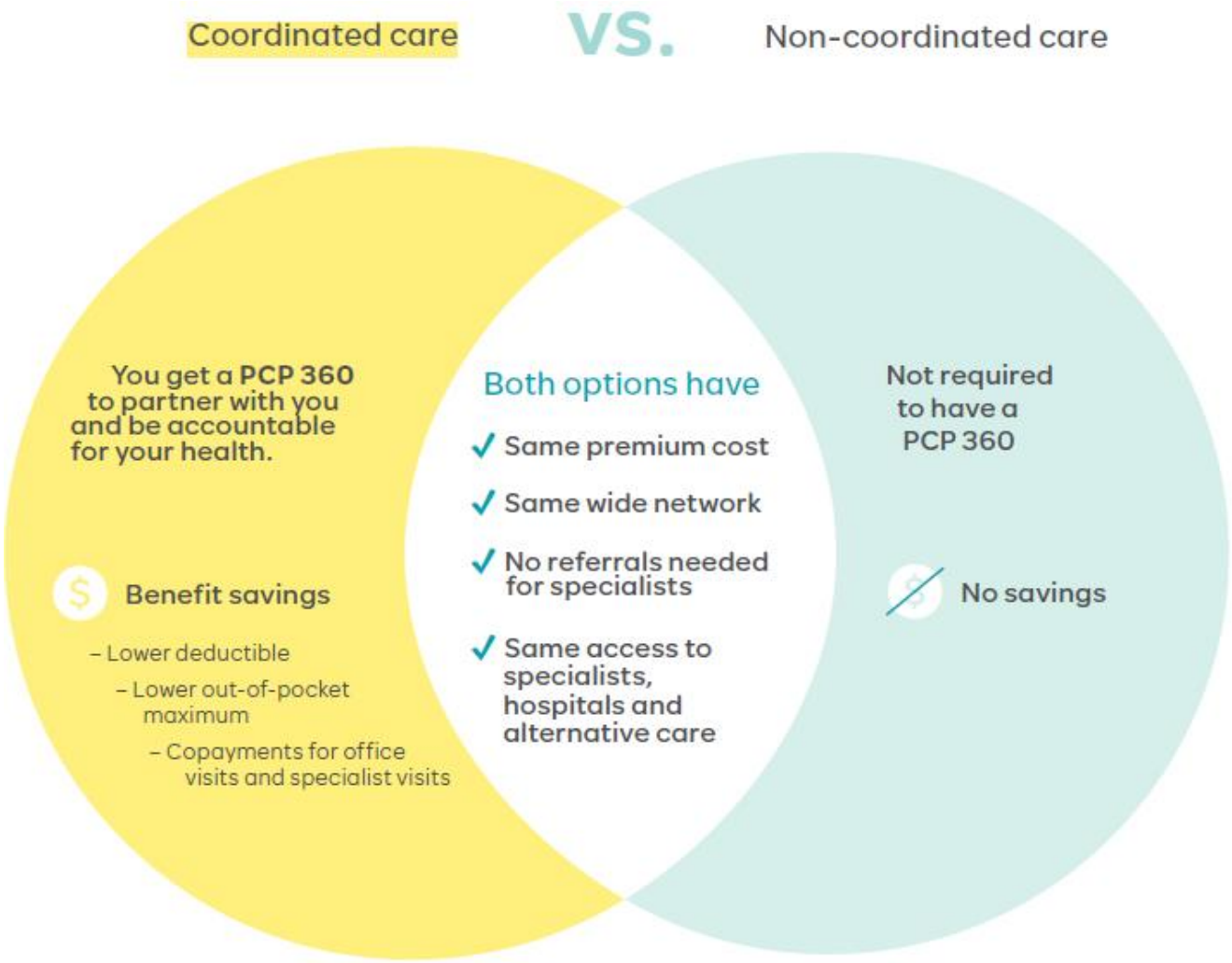
Value-based Care Programs

Value-based care

PCP 360

- Coordinated care model (CCM) for OEBB and PEBB members that focuses on Primary Care
- Encourages the use of high-performing PCPCH providers and coordinated care management
- Allows alignment with the 2019 Oregon Health System Transformation policies including:
  - PCPCH and CPC+ initiatives
  - Value-based payment models
  - Metrics alignment
  - 3.4% annual cost growth limit

PCP 360 – OEBB


Coordinated care
VS.
Non-coordinated care
You get a PCP 360 to partner with you and be accountable for your health.
Benefit savings
– Lower deductible
– Lower out-of-pocket maximum
– Copayments for office visits and specialist visits
Both options have
✓ Same premium cost
✓ Same wide network
✓ No referrals needed for specialists
✓ Same access to specialists, hospitals and alternative care
Not required to have a PCP 360
No savings

Value-based care

PCP 360 provider requirements

- Patient Centered Primary Care Home (PCPCH) certified

OR

- NCQA Patient Centered Medical Home (PCMH) certified (Bordering WA and ID counties)

AND

- Signed OEBB/PEBB coordinated care model (CCM) amendment

Value-based care

PCP 360 provider directory identification

1. 1511 Division Street Ste 102
   Oregon City, OR 97045
   503-659-4988

2. 6327 SE Milwaukie Ave
   Portland, OR 97202
   503-659-4988

3. 12360 SE Sunnyside Rd
   Clackamas, OR 97015
   503-659-4988

4. 10024 SE 32nd Ave
   Milwaukie, OR 97222
   503-659-4988

Value-based care

PCP 360 payment model

- Care Management Fee (CMF)
  - Fund the implementation of the care delivery requirements for PCPCH and/or PMH certification
- Performance Based Incentive Payment (PBIP)
  - Retrospective payments to reward performance on utilization, quality, and experience of care metrics
- Comprehensive Primary Care Payment (CPCP)
  - Prospectively paid PMPM with a corresponding Fee for Service (FFS) claims payment reduction
- Total Cost of Care Initiative (TCCI)
  - Retrospective payment for performing better than a total cost of care target

Value-based care

Provider reporting

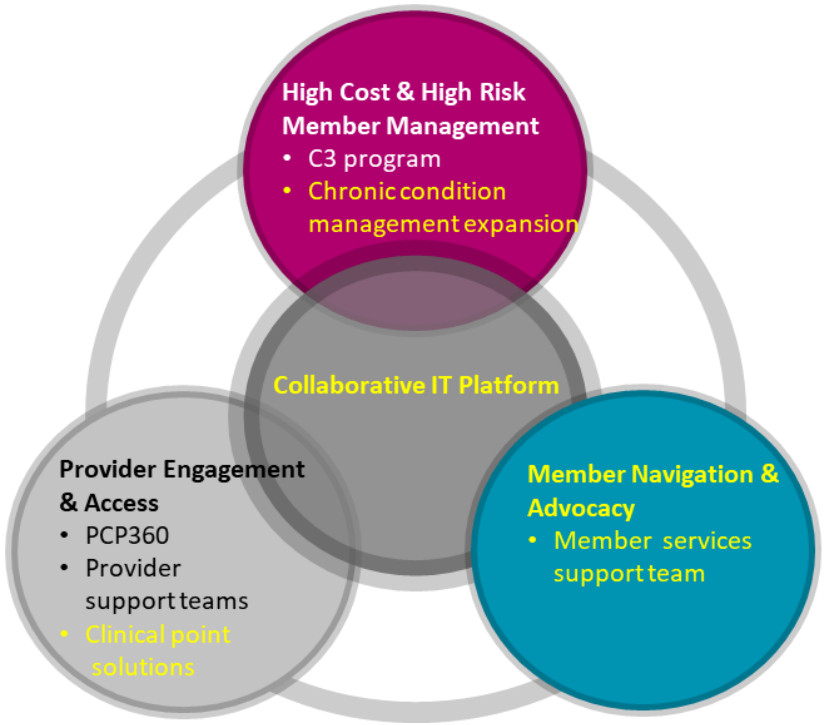
- Monthly roster
- Monthly clinical/utilization reports
- Monthly Quality Metrics reports
  - Care gap
- Quarterly financial reports
- Questions?
  - Providerreports@modahealth.com

Value-based provider reports

Data sharing/Provider Data Exchange

- Expanding data sharing arrangements for Coordinated Care Model/PCP 360, and participating CPC+ track I and II primary care practices
- Supports a collaborative approach for gaining insight into the health needs of patients and Moda Health members, by focusing on quality measurement, and clinical and claim data integration
- To learn more about participating in Moda Health's Value-based Data Sharing Program, data submission formatting guideline questions and to start sharing data, please email valuebaseddatasharing@modahealth.com

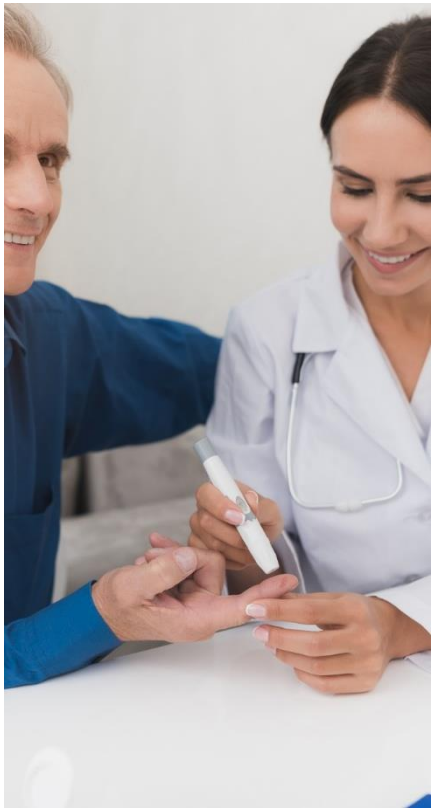
Point solutions & PCP360 coordination



Point solutions & PCP360 coordination

- Point solutions act as an extension of the provider network
- Point solution partners work with PCP360 directly
- Moda navigation & advocacy services help identify and connect members to point solutions in coordination with PCP360
- Identification of members for point solutions based on:
  - Social determinants of health data
  - Claims data
  - Care management inputs
  - Member questions and outreach
  - Clinical metrics

Diabetes support - Livongo



Digital application solution
Aggregates health data to create actionable, personalized, and timely health recommendations
Cellular-connected interactive blood glucose meter
Unlimited blood glucose test strips
Personalized health nudges support behavior change
Digital tools across mobile, web, and email, as well as coaching and monitoring
Members can share health reports with doctors, and set custom alerts to automatically navigators
Moda360 navigators support data exchange and care management between Livongo, Member and PCP360

Behavioral health – Meru

OEBB Members
11.4% Anxiety
7% Depression

Digital behavioral health clinic

- Cognitive behavioral therapy delivered remotely
- Digital application for metabolic tracking – nutrition, activity, calories
- Clinical team of providers – psychiatrists, psychologists
- Exercise and reminders for care
- Moda360 navigators support data exchange and care management between Meru, Member and PCP360

Telemedicine expansion – Chat/Text

- Chat/text solution up to 20% engagement
- Limited engagement with video & audio currently
- Convenient asynchronous communication
- Member flexibility and convenience
- Multistate Licensure
- Moda360 navigators support data exchange and care management between Cirrus, Member and PCP360
- PCP360 providers existing telemedicine solutions augmented

Commercial benefits

2021 Benefit changes

Commercial benefits

OHSU

- Magellan RX
  - Injectable Medication prior authorization
  - Clinical edits
  - Site of Care program
- Facial feminization surgery for gender reassignment

Commercial benefits

Beacon/Affinity

- Reduced copay for virtual care: $10 copay
- 24/7 Virtual Care Chat (CirrusMD): $0 cost share
- Out of area coverage for dependent students 18-26 years of age living out of state
- Digital Wellness Program, Human Coaching, Challenges (Fitbit): Scalable and provides customized support across membership base
- Behavioral Health Program: 12-week app based program (Meru) with daily support from licensed clinicians to treat common mental health conditions
- Diabetes Management Program (Livongo): enhanced diabetes management program for diabetic members including digital monitoring and nutrition support

Reconsiderations and appeals

Reconsiderations and appeals

Provider reconsiderations

When a request for prior authorization is denied, you may request a reconsideration in the following ways:

- Written or verbal request for reconsideration
- Peer-to-peer (P2P) request
- Same specialty request

Reconsiderations and appeals

Written or verbal request

- Providers may submit additional information in writing or verbally
- Within 30 days of pre-service denial
- Healthcare Services does not process a reconsideration request in the absence of new or additional information

Reconsiderations and appeals

Same specialty request

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

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

Reconsiderations and appeals

Peer-to-peer consultation

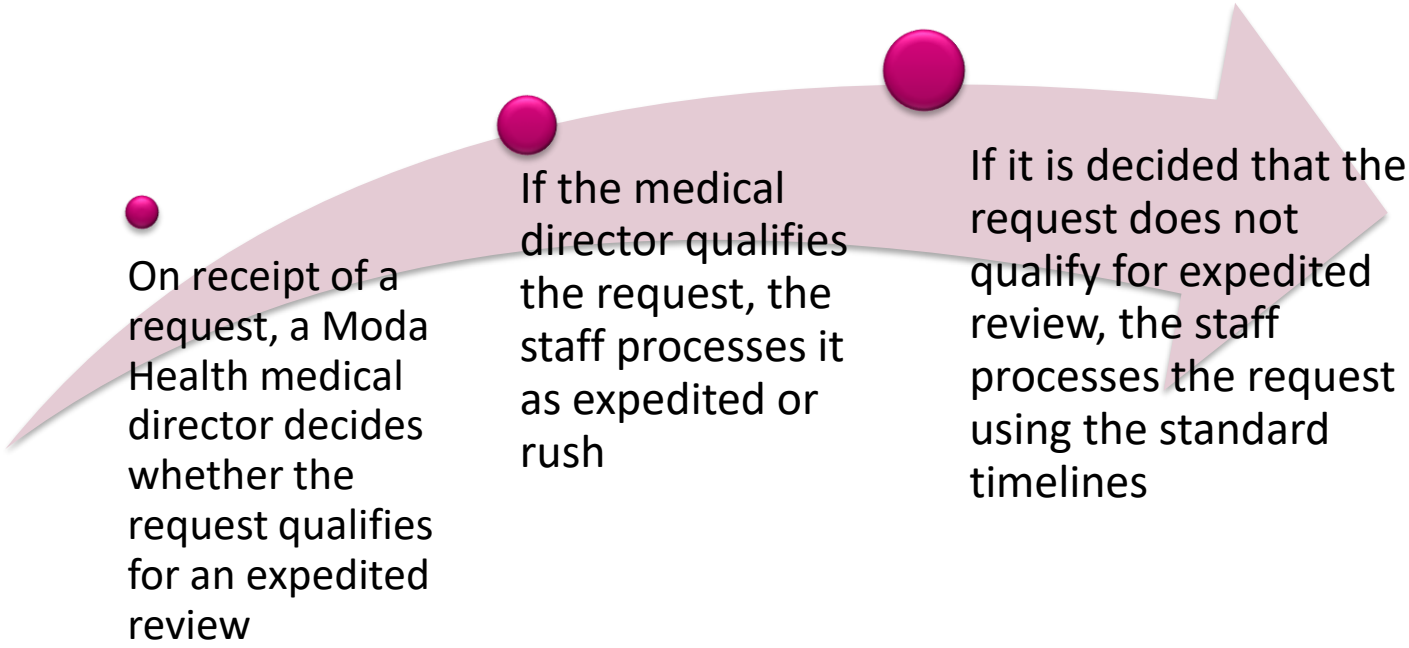
A peer-to-peer consultation is a conversation between the requesting provider and the Moda Health medical director.

- Within 10 days of the pre-service denial
- With the medical director who did the initial denial
- May give new rationale for the requested service to support medical necessity

Reconsiderations and appeals

Expedited or rush requests

An expedited or rush request is a pre-service appeal for medical care or treatment for which applying the time period for making a non-urgent care determination could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function.



Reconsiderations and appeals

Provider appeals

- Please contact customer service first for denial inquiries
- If customer service can not resolve please follow the appeals process outlined in the provider manual
- Levels of appeal
  - Inquiry
  - First level appeal
  - Final appeal

Moda Health Plan, Inc.
Provider Appeal Unit
P.O. Box 40384
Portland, OR 97240

Reconsiderations and appeals

Member appeals

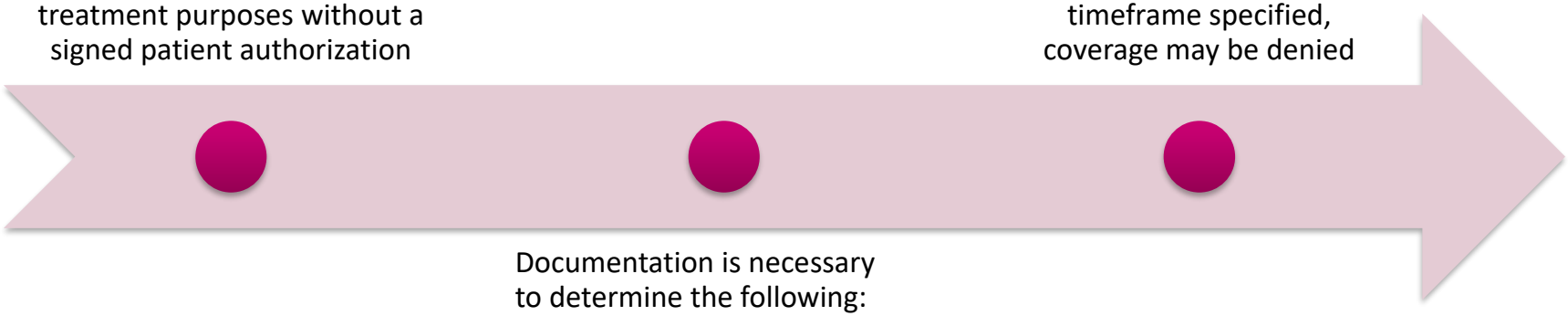
A member appeal is a pre-service or post-service appeal initiated by a member regarding an adverse determination on an authorization request or a claim.

- A provider may file a pre-service member appeal on behalf of a member in writing
- The commercial or marketplace member must complete a Moda Health Protected Health Information form modahealth.com/pdfs/auth_provider.pdf

Reconsiderations and appeals

Medical record requests

Moda Health may request medical records and supporting statements to make decisions on the preceding requests.



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

Documentation is necessary to determine the following:

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

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

Medicare Advantage updates

Medicare Advantage updates
2021 plan changes

- Summit Health Plan
  - New Medicare Advantage Plan available in Eastern Oregon Counties
  - Four HMO plans available
  - Summit Health will utilize the Moda Medicare Advantage network

Moda Medicare Advantage Participation
=
Summit Health Medicare Advantage participation

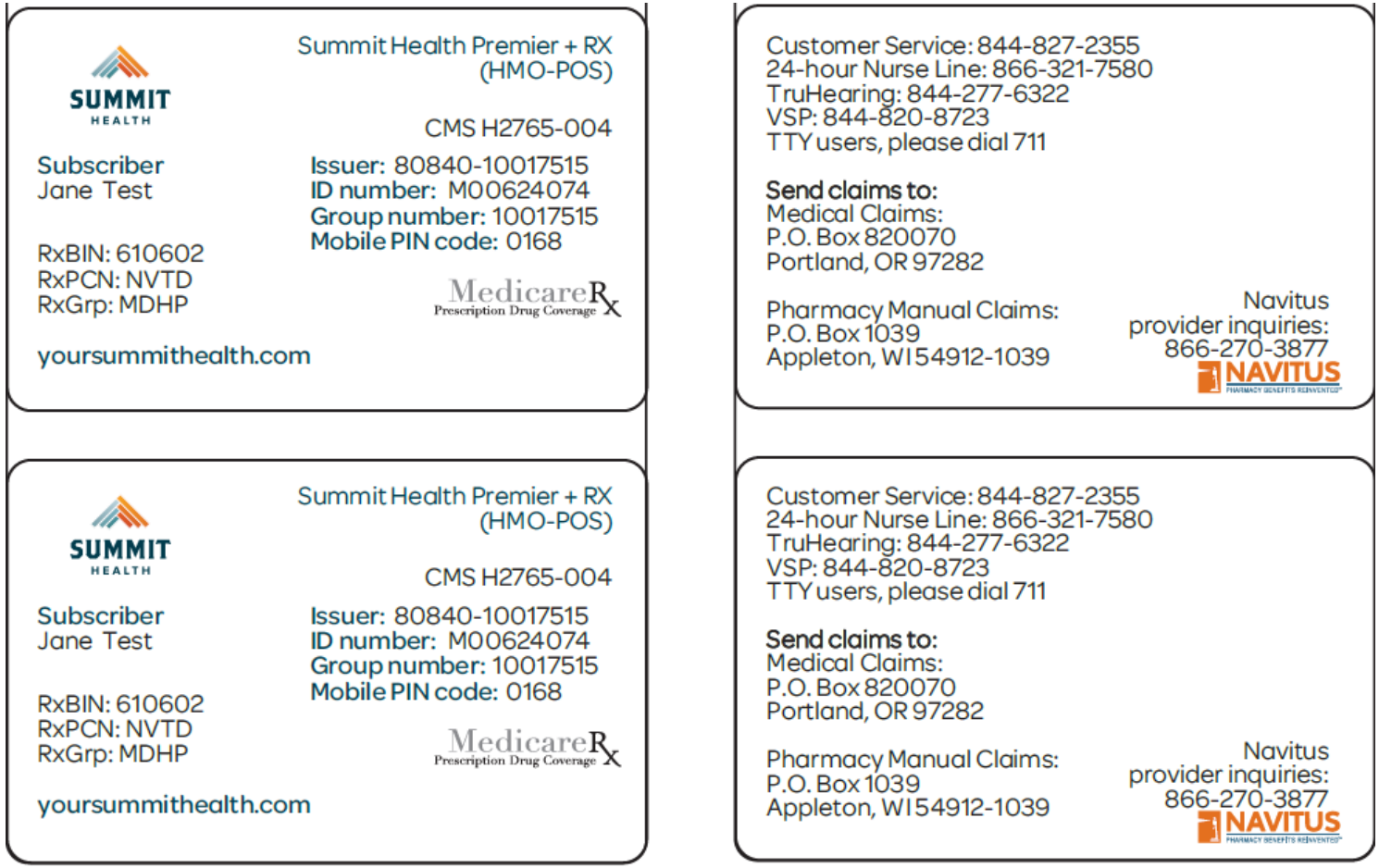
providerrelations@yoursummithealth.com

yoursummithealth.com

SUMMIT HEALTH

Medicare Advantage updates

Summit Health Plan Sample Card



Medicare Advantage updates

2021 plan changes

- Several regional Medicare Advantage plans available
- Moda Medicare Advantage plans no longer available in Clatsop County or Eastern Oregon Counties
- New option for Eastern Oregon members

Medicare Advantage updates

2021 Benefit changes

- Opioid Treatment Program (OTP)
- CMS requirements (must be met by Jan. 1, 2020):
  - Enrolled in Medicare
  - Certified by Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Accredited by a SAMHSA-approved entity
  - Approved by the Oregon Health Authority
- OHA has a list of state approved facilities oregon.gov/oha/HSD/AMH/Pages/UMATR.aspx

Medicare Advantage updates

2021 Benefit changes

- Acupuncture for Chronic Low Back Pain (cLBP) covered since 1/21/2020 (NCD30.3.3)
- Up to 12 visits in 90 days
- Additional 8 sessions covered if demonstrating improvement
  - Append modifier KX to visits 13-20
- Maximum of 20 visits per calendar year
- Physicians, Physician Assistants, Nurse Practitioners can provide Acupuncture if licensed
- Acupuncturists can provide services under appropriate level of supervision

Medicare Advantage updates

Supplemental benefits

- Dental – $500 embedded dental benefit will follow standard Coordination of Benefit (COB) rules with other dental coverage
- Vision – all routine vision services should be billed to Vision Service Plan (VSP), including refraction
- Hearing Aids – Hearing aids should be billed to TruHearing

Medicare Advantage updates

Extra Care

- Available at an additional premium per month and includes non-Medicare covered services such as:
  - Chiropractic
  - Naturopathic
  - Acupuncture
- 50% coinsurance for services up to a $500 maximum benefit per year
- Extra Care enrollment can be verified in EBT

Patient name:

GENDER	RELATIONSHIP	BIRTH DATE	PLAN BEGIN	PLAN END	STATUS	COB BEGIN	COB END
Male	Subscriber		01/01/2017	--/--/----	Active		

Notes

Extra Care Benefit: 50% to a combined maximum benefit of $500 per calendar year for all care (in and out-of-network) for glasses, contacts, hearing aids, hearing test, acupuncture, naturopathic care, and chiropractic services that are not covered under the basic Moda Advantage plan. Extra care benefits do not require prior authorization.

Manual manipulation of the spine to correct subluxation is covered under the basic plan according to Medicare Guidelines. Chiropractic services no longer require prior authorization effective 7/1/16.

Medicare Advantage updates
Supplemental benefits

- Silver&Fit benefit
  - available on most Medicare Advantage plans
- Fitbit
  - Replaces Silver & Fit for the NW Medicare Advantage Plan
  - No cost Fitbit device plus a premium subscription
- Livongo
- Cirrus MD

Medicare Advantage updates
Medication Therapy Management Program

Members are eligible for participation if they meet all of the following criteria:

- Have two or more of the following chronic conditions:
  - Diabetes
  - High blood pressure
  - Asthma
  - Osteoarthritis
  - CHF (chronic heart failure)
  - High cholesterol
  - Depression
  - COPD
  - HIV/AIDS
  - Rheumatoid arthritis
- Take five or more medications
- Have drug costs that total $4,376 or more annually

Medicare Advantage updates

Organization Determinations

CMS established Part C or Medicare Advantage rule about proper notice of non-coverage to Medicare Advantage members

- No longer allowed to utilize an Advanced Beneficiary Notice (ABN)
- Only a Part C or MA plan can issue a notice of non-coverage through an organization determination

Medicare Advantage updates

Plan Directed Care

- Ensures Medicare Advantage plan members receive medically necessary services that are covered by their Moda Health Medicare Advantage health plan
- **Referrals to non-participating providers** – Participating providers referring Medicare Advantage members to non-participating physicians, providers or agencies must obtain prior authorization for certain procedures and services as outlined in the Moda Health Medicare Advantage agreement

Medicare Advantage updates

Compliance attestation

- Attestation will be online
- Information attesting to:
  - Reporting mechanisms & disciplinary standards
  - Sub-delegation contracts
  - Off-shore activities
  - OIG and GSA screening
- For questions, please email delegatecompliance@modahealth.com or providerattestation@modahealth.com

Medicare Advantage updates

Provider directory outreach

- CMS mandates that Medicare Advantage plans verify provider demographic information on a quarterly basis
- Types of information we are required to validate include:
  - Practicing location
  - Accepting new Medicare patients status
  - Phone number
  - Provider specialty
- Roster outreach and phone validation
- Participating Medicaid/EOCCO practices will need to submit additional information

Be better