Moda Health PPO & EPO

Texas Commercial Participating Provider Manual

moda HEALTH

Contents

Introduction

The Moda Health Participating Provider Manual is intended to give participating providers helpful and reliable information and guidelines regarding Moda 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 Moda Health as a participating provider. Updates to this manual will be posted to the Moda Health website or communicated to you via newsletter.

Where permitted by law, this manual supplements the terms of the participating provider agreement you entered into with Moda Health. If any provision of this manual is contrary to the laws of the state in which services are provided, 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 individual members, and our participating physicians and providers.

Non-discrimination of Health Care Service Delivery

Moda Health complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials and physical locations that serve our members. All Providers who join the Moda Health Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Moda Health requires Providers to deliver services to Moda Health members without regard to race, color, national origin, age, disability or sex. Providers must not discriminate against members based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of member financial responsibility from Moda Health members.

Contacts and important phone numbers

Provider Recruitment & Relations
Email: TXprovidernominations@modahealth.com
Phone: 833-949-1884
Contact Provider Recruitment & Relations for:

- Initial contracting or credentialing questions
- Assistance with provider education materials and training

Appeals and complaints
Phone: 866-923-0412
Fax: 503-412-4003
Email: TexasAppealReview@modahealth.com

Benefit Tracker
Phone: 877-277-7270
Email: ebt@modahealth.com

Credentialing
Email: credentialing@modahealth.com
Fax: 503-265-5707
Mail: Moda Health
Attn: Credentialing Dept.
601 SW 2nd Ave. #900
Portland, OR 97204

Medical Customer Service
Email: medical@modahealth.com
Phone: 844-827-6571 for individual products
844-931-1779 for group products

Pharmacy Customer Service
Phone: 844-931-1780

Healthcare Services: Case management & disease management
Phone: 800-592-8283
Fax: 503-243-5105

Electronic Data Interchange
Email: edigroup@modahealth.com
Phone: 800-852-5195

800-799-9391 for behavioral health**Disease Management and Health Coaching**
Phone: 855-466-7155

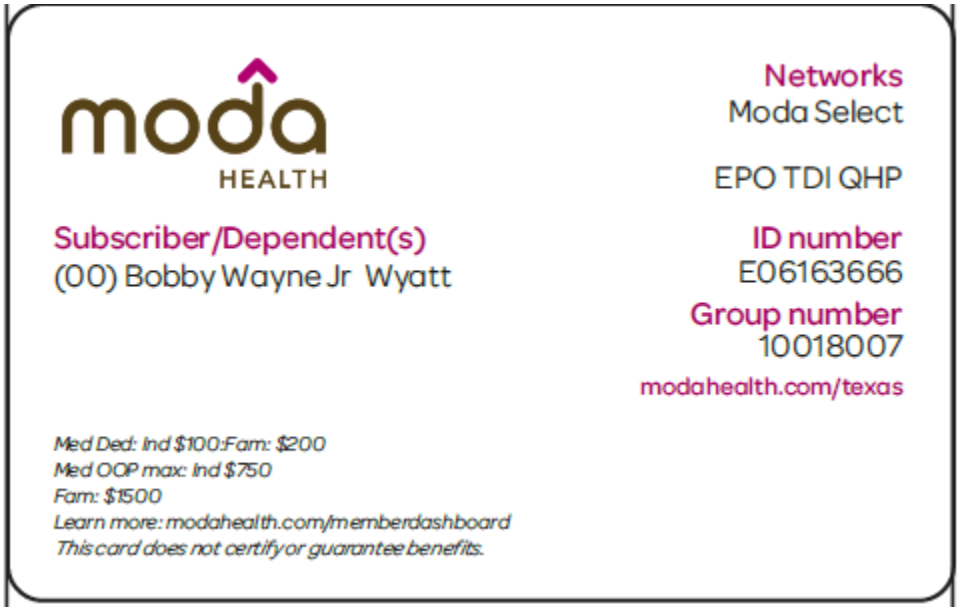
Referral/Prior Authorization Intake
Medical: 888-474-8540 or 800-258-2037 (phone), 800-522-7004 (fax)
Expedited medical: 888-474-8540 or 800-258-2037 (phone), 503-243-5105 (fax)
Behavioral Health: 855-294-1665 (phone), 503-670-8349 (fax)
Pharmacy: covermymeds.com

Fraud, Waste and Abuse
Reporting healthcare fraud
By email: stopfraud@modahealth.com
By phone: 855-801-2991
By mail: Attn: Special Investigations Unit
Moda Health Plan, Inc.
604 SW Second Avenue
Portland, OR 97204

ID Card Sample

As part of the 2021 Consolidated Appropriations Act (CAA) requirements, starting in 2022 we will display individual, family and group medical plan deductibles and out-of-pocket maximums on the front of physical and electronic member ID cards. The cards will also include a phone number and website address. While other deductibles and out-of-pocket maximums for prescription drugs will not be included on ID cards at this time, you can find this information in Benefit Tracker or by calling Customer Service.

EPO individual - Front



EPO individual - Back

Card abbreviation key:

EPO	Exclusive Provider Organization
TDI	Insured plan
QHP	Individual Exchange plan
Med	Medical
Ded	Deductible
Ind	Individual
Fam	Family
INN	Individual
Individual	Out-of-network
OOP max	Out-of-pocket maximum
Motorcycle Health	Patient is covered for injuries incurred as a result of an accident while operating or riding on a motorcycle.
RX	Pharmacy benefits
RX tier/copay	Value/Select/Preferred/Non-Preferred/Preferred specialty/Non-preferred specialty tiers

Secure Provider Portal: Benefit Tracker

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

- Patient eligibility
- Medical benefits
  - With a link to the member's certificate or policy
- Claim status information
  - View claims online before the explanation of payment (EOP) arrives.
  - Printable EOB available as the claim is processed (The information displayed is the same as the member's EOB.)

Benefit Tracker is a HIPAA-compliant and state compliant online service.

After-hours usage
Benefit Tracker is available seven days a week, 365 days a year. It is available all hours 24/7 including weekends and holidays. Benefit Tracker is occasionally unavailable for site maintenance. A message will be posted if the site is unavailable.

Benefit Tracker support is available by contacting us at 877-277-7270; or email us at ebt@modahealth.com

Getting started
To sign up online, visit modahealth.com/medical/mbt.shtml 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).
  - Return it to Moda Health via email to ebt@modahealth.com.

- Complete registration.
  - Have all Benefit Tracker users create their own username and password online.

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

Provider administration and role of the provider

Provider types that may serve as PCPs

Primary care provider (PCP) is a physician who is responsible for providing care to patients, maintaining the continuity of patient care, and initiating referral for care. Providers who may serve as primary care providers (PCP) are licensed as an MD, DO, NP, or PA and specializes in Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics, or Geriatrics.

Members with chronic, disabling or life-threatening illnesses may apply to our Medical Director to utilize a non-primary care physician specialist as a PCP. The request must include a certification by the non-primary care physician specialist of the medical need for the member to utilize the non-primary care specialist as a PCP, a signed statement by the non-primary care specialist that he or she is willing to accept responsibility for the coordination of all the member's health care needs and the member's signature. The non-primary care physician must meet Moda Health's requirements for PCP participation, including credentialing. Moda Health will approve or deny the request within 30 days of receiving the request, if the request is denied the written notification will outline the reasons for the denial of the request. A member may appeal the decision through our complaint and appeal process. If approved, the designation of a non-primary care physician specialist as the member's PCP will not be applied retroactively or reduce the amount of compensation owed to the original PCP for the services provided before the date of the new designation.

The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, or similar outpatient clinic.

Member panel capacity

If a provider has reached the capacity limit for their practice and wants to make a change to their open panel status, the provider must notify Moda Health 30 days in advance of their inability to accept additional members. Notification should be in writing to the Provider Configuration department at texasproviderupdates@modahealth.com.

Withdrawing from caring for a member

Providers may withdraw from caring for a member. Upon reasonable notice and after stabilization of the member’s condition, the provider must send a certified letter to Moda Health Customer Service detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

PCP coordination of care with specialists

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. Plan notification referrals are not required.

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

Specialist provider responsibilities

Specialist providers must communicate with the PCP regarding a member's treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request. To ensure continuity and coordination of care for the member, every specialist provider must:

- Maintain contact and open communication with the member's referring PCP
- Obtain authorization from Healthcare Services, if applicable, before providing services
- Coordinate the member's care with the referring PCP
- Provide the referring PCP with consultation reports and other appropriate patient records within five business days of receipt of such reports or test results
- Actively participate in and cooperate with all quality initiatives and programs

Appointment availability and wait times

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

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 3 weeks of the request.

Behavioral Health appointment standards are:

- Members requiring urgent care are seen within 24 hours of request.
- Appointments for initial routine office visits are scheduled within two weeks.
- Appointments for follow up routine office visits are scheduled within two weeks.

Specialist appointment standards are:

- Appointments for routine office visits are scheduled within two weeks.

Provider phone call protocol

PCPs and specialist providers must:

- Answer the member's telephone inquiries on a timely basis
- Schedule appointments in accordance with appointment standards and guidelines set forth in this manual
- Schedule a series of appointments and follow-up appointments as appropriate for the member

and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients
- Adhere to the following response times for telephone call-back wait times:
  - After hours for non-emergent, symptomatic issues: within 30 minutes
  - Same day for all other calls during normal office hours
- Have protocols in place to provide coverage in the event of a provider's absence

Provider data updates and validation

Moda Health believes that providing easy access to care for our members is extremely important. When information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) about your practice, your locations, or your practitioners changes, it is your responsibility to provide timely updates to Moda Health. Moda Health will ensure that our systems are updated quickly to provide the most current information to our members.

Additionally, Moda Health performs regular audits of our provider directories. This may be done through outreach to confirm your practice information or requests for roster submission. Access to care is critical to ensuring the health and well-being of our members, and in order to provide reliable access to care, it is important to respond to the outreach. Without a response, we are unable to accurately make your information available to patients and you may be at risk of being removed from our provider directory, Find Care.

We need your support and participation in these efforts. CMS may also be auditing provider directories throughout the year, and you may be contacted by them as well. Please be sure to notify your office staff so that they may route these inquiries appropriately.

24-hour access to providers

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 Moda Health participating provider for continuous coverage to meet the medical needs of Moda Health members.

Moda Health verifies on-call and after-hours coverage at the time of initial credentialing and at each recredentialing and monitors through member complaints and, if applicable, the office site audit and other surveys.

Hospital responsibilities

Moda Health has established a comprehensive network of hospitals in the network service area to provide services to members. Hospital services and hospital-based providers must be qualified to provide services under the program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by accrediting agencies, if any, and Moda Health.

Facilities are required to notify Moda Health Medical Intake of all hospital admissions and discharges within 24 hours or the next business day. Urgent/emergent admissions and elective admissions require notification.

Verifying member benefits, eligibility and cost shares

There are four ways that you can verify member eligibility and benefits with Moda Health. It can be done electronically, by email, or by calling a Moda Health customer service representative. 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#)

OPTION 1: Use Benefit Tracker (Preferred Method)

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 certificate or policy. Benefit Tracker is available seven days a week, 24 hours a day.

OPTION 2: Contact us by e-mail: medical@modahealth.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 9:30 a.m. to 7:30 p.m. Central Time, excluding holidays.

OPTION 3: Call Customer Service at 844-827-6571 for Individual plans and 844-931-1779 for Group plans

Armed with the very latest details on all policies and procedures, our customer service staff will always give you the information available. You can reach them Monday through Friday from 6:00 am to 6: pm on Central Time on weekdays and 9:00 am to noon Central Time on weekends and legal holidays.

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

This is an electronic exchange of eligibility and benefits 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 using this method, we will work with the provider to accomplish it.

Medical Management

Utilization Management

The Moda Health authorization guidelines provide information for authorization request requirements. **This information is subject to change and can be accessed on the Moda Health website under Provider, Coverage and Claims, Authorizations and referrals.**

Prior authorization is a review conducted prior to a service being rendered to ensure that nationally recognized standards of medical evidence are met.

Services requiring prior authorization through Moda Health
For a list of services that require prior authorization through Moda Health, please visit modahealth.com/texas/provider/coverage-and-claims/prior-authorizations-and-referrals or call the Moda Health Medical Intake department toll-free at 800-258-2037.

Procedure for Requesting Prior Authorizations

Requests for prior authorizations can be made by fax or phone. Instructions are found on the Moda Health website. The prior authorization form is available on the Moda Health website at: modahealth.com/pdfs/referral_form.pdf

Authorizations are subject to plan benefits and limitations. An authorization does not guarantee payment. Contact Customer Service or check Benefit Tracker for benefit limitations and exclusions. To receive the higher level of benefit, services must be performed by participating providers/facilities on preferred provider (PPO) or exclusive provider (EPO) plans.

Note: If services are not authorized prior to being rendered, certain plans may apply a cost containment penalty, even when services are authorized after the service has been provided.

If a contracted provider fails to obtain prior authorization when required services will be subject to a penalty of 50% of covered charges up to a maximum deduction of $500 per occurrence before regular plan benefits are computed. The member may not be balance billed.
Note: Authorizations are not required when Moda Health is not the primary payer.

Utilization Determination - Timeframes

Moda Health will conduct utilization review in the following timeframes for

Types	Timeframes
When members are not hospitalized	2 business days or 72 hours whichever is lesser
Inpatient care when members are hospitalized	1 business day or 24 hours, whichever is lesser
Post-stabilization care following emergency treatment	With 1 hour
Brain injury	2 business days or 72 hours whichever is lesser
Concurrent review of the provision of prescription drugs or intravenous infusions	30 calendar days
Retrospective	30 calendar days

Please note: Self-funded plans may follow federal timeframes.

INVESTIGATIONAL SERVICES AND SUPPLIES
Services that are considered always not covered, always not medically necessary or always investigational will be denied as member responsibility. Our screening criteria will include flexibility to allow a deviation from the norm when justified on a case-by-case basis.

Denials

Moda Health members and providers are notified of prior authorization decisions on a timely basis. The specialist or requesting provider is notified verbally or via facsimile when the review and decision are complete and a written notice subsequently. Denial letters will include the principal reason for denial and the internal and external appeal process.

Opportunity to discuss before denial is issued

Before issuing a denial based on medical necessity, appropriateness, experimental or investigation reason, Moda Health will provide the ordering health care provider an opportunity to discuss, at a minimum, the treatment plan, the clinical basis of our determination and a description of documentation or evidence, if any, that can be submitted by the health care provider that, on appeal, might lead to a different utilization review decision.

Care Management and Concurrent Review

Moda Health requires prior authorization of all elective/scheduled inpatient hospitalizations when Moda Health is the primary payer. This is to ensure that care is delivered to Moda Health members in the appropriate setting by participating providers. Our plans have a cost containment penalty that will apply if an inpatient stay does not have prior authorization. The specifics are listed in the certificate or policy.

If a contracted provider fails to obtain prior authorization when required services will be subject to a penalty of 50% of covered charges up to a maximum deduction of $500 per occurrence before regular plan benefits are computed.
Moda Health provides benefits for urgent/emergency hospital admissions.

NOTIFICATION REQUIREMENTS
Facilities are required to notify Moda Healthcare Services of all hospital admissions and discharges within 24 hours or the next business day. Urgent/emergent admissions and elective admissions require notification.

If a contracted facility fails to notify Moda Health of admissions and discharges within the required timeframe, the admission may be denied for lack of medical necessity.

INPATIENT CONCURRENT REVIEW
Moda Health will perform inpatient concurrent review for selected admissions. If a contracted provider fails to participate in the concurrent review process (including failure to respond to record requests), additional hospital days may be denied for medical necessity.

Claims

Please note: Self-funded plans may have different timelines and requirements for claims submission, payment and recovery.

Timely Filing

All eligible claims for covered services must be submitted no later than 120 days after the date of service or providers will forfeit their right to payment unless late filing was the result of a properly certified catastrophic event. The absence of legal capacity constitutes the only exception to this policy. Participating providers (direct contract or secondary networks) may not balance-bill the member for services that were denied for not meeting the timely filing requirements.

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).

Claims may not be submitted before the date of service. For services billed with a date span (e.g., DME rentals or infusion services), claims must be submitted after the end date of the billing.

If an explanation of payment (EOP) is not received within 30 days of submission of the claim, the billing office should contact Customer Service 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.

Any adjustments needed must be identified and the adjustment request received in a timely manner. Timely filing requirements for adjustment requests are addressed under “Recovery of Over/Under Payments to Providers.”

Timely Filing Limits

Initial Claims	Coordination of Benefits Claims (Moda Health is secondary to another carrier)	Corrected or Reconsideration Claims, Claims Dispute or Appeal	Final Appeal
Calendar Days	Calendar Days	Calendar Days	Calendar Days
120	120	120	60

- Initial Claims – Days are calculated from the date of service to the date received by Moda Health*. For observation and inpatient stays, days are counted from the date of discharge.
- Coordination of Benefits Claims – The 120-day period for filing a clean claim to a secondary carrier does not begin to run until the provider receives notice from the primary payer of the amount of the claim it has paid, or that it has denied the claim. If a member does not inform Moda Health of other coverage until after 120 days after the date of service, Moda Health may work with the provider to extend the period for submitting a claim. Moda Health must accept, as proof of timely filing, information from another carrier showing the claim was timely filed.
- Wrong Carrier - If a claim is timely filed to the wrong carrier that proof of submission can be used as proof of timely filing. This provision does not apply to claims timely filed to a workers' compensation or automobile carrier.
- Catastrophic Events – If a provider experiences a catastrophic event and is unable to meet the claim submission deadlines, the provider must notify the Texas Department of Insurance (TDI) within 5 days of the catastrophic event. Within 10 days after the provider returns to normal business operations, the provider must send a certification to TDI and identify the specific nature and date of the catastrophic event, and the length of time the catastrophic event caused an interruption in the claims submission or processing activities of the provider.
- Corrected/Reconsideration Claims, Claim Disputes & Appeals – Days are calculated from the date of the explanation of payment (EOP) issued by Moda Health to the date received by Moda Health*.
- Final Appeal - Days are calculated from the date of the First Appeal response letter issued by Moda Health to the date the Final Appeal from the provider is received by Moda Health*.

**Date received by Moda Health is determined based on method of submission under Texas rules:*

- Sent by mail - Presumed to have been received by the insurer on the 5th day after the date the claim is mailed.
- Sent using overnight service or return receipt requested - The received date is the date the delivery receipt is signed.

- Sent by hand delivery - Any method of hand delivery to Moda Health must require a signed delivery receipt. The received date is the date the delivery receipt is signed.
- Claims submitted electronically - The received date is recorded by the electronic data interface (EDI).
- Sent by fax (not initial claims) - The received date is the date of the transmission acknowledgement. This applies to records, additional information, etc. but not to Initial Claims submission. Initial claims are not accepted by fax.

In order to avoid dispute, providers may maintain some documentation that the claim was actually mailed. If a provider has not used a mail log or other similar method and has no other way to prove whether or when the claim was mailed, the received date would default to Moda Health's received date stamp if the claim was received in our office. If the claim was not received at our office and no mail log or other agreed-upon method was used to document receipt of first-class mail, then the provider would have no way to create a presumption of claims receipt.

For more information about Inquiries and Appeals, see Provider Inquiries And Appeals and Recovery Of Over/Underpayments to Providers.

Who Can File Claims?

All providers who have rendered services for Moda Health members can file claims. It is important that providers ensure Moda Health has accurate and complete information on file. Please confirm with the Provider Services Department or your dedicated Provider Relations Representative that the following information is current in our files:

1. Provider Name (as noted on current W-9 form)
2. National Provider Identifier (NPI)
3. Group National Provider Identifier (NPI) (if applicable)
4. Tax Identification Number (TIN)
5. Taxonomy code (This is a REQUIRED field when submitting a claim)
6. Physical location address (as noted on current W-9 form)
7. Billing name and address (as noted on current W-9 form)

We recommend that providers notify Moda Health 30-60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of the year 1099 IRS form will be mailed, a new W-9 form will be required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form or a 277 electronic file.

Filing a claim

Participating providers agree to bill Moda Health directly for covered services provided to members with coverage through Moda Health. Once the coverage through Moda Health has been verified through Moda Health Customer Service or online using Benefit Tracker, members should not be asked for payment at the time of services except for deductible, copayments, coinsurance and for services not covered.

Electronic Claims Submission

Please file all claims using the Institutional 837 (ASC X12N 837) format or a successor to that format adopted by CMS, and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements. Moda Health does 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 800-852-5195.

Paper Claim Submission

Send paper claims to:
Moda Health
Attention: Medical Claims
P.O. Box 40384
Portland, OR 97240

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.

For more information about the claim forms, please see instructions for completing the CMS 1500 or UB04/CMS 1450 forms located in a separate section in this manual or by going to nubc.org.

Use your Provider Number

In order for claims to be processed correctly, each claim must include the correct Tax ID Number (TIN) and National Provider ID (NPI). 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.

Split Claims

As much as possible, all procedure codes for a single date of service should be submitted at the same time on a single claim form. Submitting additional charges at a later date on a separate claim creates a split claim for the date of service and makes correct processing of the claim more difficult. Split claims should 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 of 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. This claim needs to be clearly identified as a "corrected claim."

Duplicate Claims

Please contact Moda Health Customer Service or check Benefit Tracker before submitting duplicate claims. Rebilling without contacting us slows our turnaround time and delays payment. Line items or units identified as duplicates will be denied.

- Medical claims - Participating providers may not submit a duplicate claim before the 46th day, or the 31st day if filed electronically, after the date the original claim is received.
- Pharmacy claims - Participating providers may not submit a duplicate claim for prescription benefits before the 22nd day, or the 19th day if filed electronically, after the date the original claim is received

To see the status of a claim, check the Benefit Tracker. If you haven't registered for this free online service and would like more information, see the Moda Health website at modahealth.com/medical or contact the Benefit Tracker administrator by phone at 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. Providers with a pattern of chronically submitting multiple copies of claims may be contacted for corrective action.

Before Resubmitting Claims

If a claim is denied, the provider must resolve the reason for denial before resubmitting the claim. Please refer to the explanation code to help determine what issue needs to be addressed. Certain claims may also have denial correspondence that is helpful. Resubmitting a denied claim without taking corrective action will result in continued claim denial.

Corrected Claims

A corrected claim needs to be submitted whenever the provider is adding to or changing the original claim. For example, changing procedural codes, modifiers, diagnosis, dates, units, or other information, or adding surgical codes. Corrected claims must clearly identify they are corrected in one of the following ways:

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

    Moda Health
    Attention: Corrected Medical Claims
    P.O. Box 40384
    Portland, OR 97240

    a. 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.
    b. 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.
    c. A handwritten or stamped notation indicating “corrected claim” may also be added.

The corrected claim should 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 and attach records for the services billed to verify the coding change is appropriate. Corrected claims received without accompanying records may result in denials.

It is not appropriate to move charges from a denied line item and add them to charges for an allowed line item. “Corrections” of that nature will result in denial.

Clean Claim

A clean claim consists of data elements on CMS 1500 and UB 04* claim forms that are required or conditionally required by Texas rules for non-electronic claims. Claims to secondary carriers must disclose amounts paid by the primary carrier. Electronic claims must comply with all federal laws applicable to electronic claims, implementation guides, companion guides, and trading partner agreements. Data elements must be complete, legible, and accurate. Additional data elements or information does not render the claim deficient.

The information specified by Texas rules must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim.

Coordination of Benefits (COB) 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 the 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 Texas and federal laws and regulations and applicable language in the health benefit plans issued by Moda Health. Please refer to the member's certificate or policy for specific details.

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

If your patient is covered by more than one Moda Health plan, submit one claim form indicating the name of the subscriber, subscriber ID, employer (if applicable), and Moda Health group number for both plans. **It is not necessary to send in two separate claims.**

Recovery of Over/Underpayments to Providers

Providers are entitled to request an adjustment of payment if they notify Moda Health of an underpayment within 270 days after the underpayment was received. Prompt pay penalties apply to valid underpayments unless the notification of underpayment is received after 270 days after initial payment, and we pay the balance within 30 days from receipt of the request. Any request for a corrective adjustment must specify the reason as to why the requesting entity believes it is entitled to an adjustment.

Moda Health is entitled to overpayment recovery if we notify the provider of an overpayment within 180 days following the date of payment in question or upon completion of an audit. Notification of overpayment must include the basis and specific reason for requesting a recovery, the methods Moda Health intends to use to recover the funds and the provider's right to appeal. If the provider does not agree with the overpayment recovery request, Moda Health will provide an

opportunity for the provider to appeal, and we will not recover the overpayment until all appeal rights are exhausted.

For claims involving coordination of benefits, Moda Health may not recover a refund until Moda Health as the secondary plan, first recover overpayment from the primary plan payor. Moda Health may recover from the provider only if both primary and secondary payors paid the amount to the provider.

If a provider does not appeal a refund request in writing within 45 days of the date of the request for refund, the request is deemed accepted and the refund must be paid. If the provider appeals the refund request, Moda Health will not recover a refund until the provider's appeal rights are exhausted or within 45 days after the notice of the refund, whichever is later. To obtain a refund, 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.

Remittance of Overpayments

When there is a need to send Moda 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 Customer Service at 888-217-2363 to resolve the matter. The provider has appeal rights by contacting Moda Health within 45 days of receipt of a refund request.

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" located under "Provider Resources/ Forms, policies and manuals" on the Moda Health website. Simply print the 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 Customer Service:

- Via telephone at 844-931-1779 for group plans and 844-827-6571 for individual plans, or
- Via email link at our website, medical@modahealth.com

If your request is not resolved to your satisfaction, send a written request to Moda Health. The letter should indicate the specific claim you are writing about, and it should 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 should 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.
Provider Appeal Unit
P.O. Box 40384
Portland, OR 97240

See also Overpayment Prevention section.

Coding, Editing, & Reimbursement

Moda Health Reimbursement Policy Manual

The Moda Health Reimbursement Policy Manual addresses a number of major administrative policies, payment policies and other significant reimbursement issues. The policies it contains affect and apply to you as a Moda Health provider. The manual can be found on the Moda Health website at modahealth.com/medical/policies.shtml.

Disclosure notices subject to Title 28 of the Texas Administrative Code are posted at least 90 days in advance of the effective date of the change. For out-of-network providers, the policy will be effective on the date the policy is posted to the provider website.

Correct Coding and Billing

Claims are to be submitted using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, ICD-10-CM and -PCS guidelines, DRG guidelines, AHA Coding Clinic, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Clinical Editing Policy & Sources

Moda Health uses 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, modifier, 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.

The Moda Health 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

See Reimbursement Policy RPM002, "Clinical Editing."

Reimbursement and Editing Principles

Selecting Procedure Codes, Unlisted Codes

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

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

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 should 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) are not appropriate. These items are already included in the practice expense portion of the fee allowance, and so 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)."

International Classification of Diseases (ICD)

The current ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes and guidelines for the date of service need to be used.

Incomplete Diagnosis Codes

Diagnosis codes must be complete, valid, and include all required digits and characters. These requirements apply to all diagnosis codes billed in any position, on all claims, and is applicable in all settings from all provider types.

If a claim is billed with one or more incomplete diagnosis codes, the claim will deny; a corrected claim will be needed. See Reimbursement Policy RPM053, “Diagnosis Code Requirements - Level Of Detail and Number of Characters.”

Inappropriate Diagnosis Codes in the Primary Diagnosis Position

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. This CMS list is also applied to Commercial claims. Inpatient facility claims billed with an invalid primary diagnosis code for the setting will deny; a corrected claim will be needed. See Reimbursement Policy RPM054, “Diagnosis Code Requirements - Invalid As Primary Diagnosis.”

Revenue Codes

Moda Health does not accept revenue codes ending with "9" (“Other” categories, e.g., 0XX9); they are considered to be unlisted revenue codes. Select a more specific revenue code ending in "1," "2," "3," "4," "5," "6," "7," or "8" which applies, or if necessary, the appropriate general revenue code ending with "0." See Reimbursement Policy RPM042, “Revenue Codes Ending in "9" ("Other" Categories).”

Moda Health does not allow split-billing of Provider-based clinic services; revenue codes 0510 – 0519 are not reimbursable. Moda Health requires all facilities to bill the physician’s professional services on a CMS-1500 form or its electronic equivalent. The only exceptions to this policy are all-inclusive-rate hospitals and critical-access hospitals (CAHs). See Reimbursement Policy RPM061, “Clinic Services In the Hospital Outpatient Setting - Commercial.”

Multiple Procedure Reductions

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

Incidental Procedures

Certain procedures are considered “incidental” and are not eligible for payment as secondary procedures. An incidental procedure is one that does not add significant time or complexity to the major procedure. Incidental procedures are not eligible for separate reimbursement. Please see the information about our clinical editing policy listed in this manual.

Bilateral Procedures

See reimbursement policy RPM057, "Modifier 50 – Bilateral Procedure."

Reduced or Discontinued Procedures

See:

- Reimbursement policy RPM003, "Modifier 52 — Reduced Services."
- Reimbursement policy RPM018 "Modifier 53 — Discontinued Procedure."
- Reimbursement policy RPM049, "Modifiers 73 & 74 - Discontinued Procedures For Facilities."

Co-surgery Reimbursement

See reimbursement policy RPM035, "Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons)."

Overpayment Prevention

Moda Health is committed to accurate adjudication of claims to ensure members' benefits are properly applied, for good stewardship of member and employer group premium payments, and to ensure providers are fairly and accurately reimbursed for services rendered. Accurate reimbursement includes overpayment prevention. Our program for prevention of overpayments includes:

- Clinical editing
- Prepayment reviews
- Postpayment reviews
- Use of vendor services and review vendors

Claim Reviews

During the normal course of our claims processing, claims will be selected for review to ensure correct coding, completeness of documentation, billing practices, contractual compliance, and any benefit or coverage issues that may apply. Services are expected to be billed with correct coding and billing. Reviews are performed to identify overpayments as well as uncover and identify unacceptable, misleading billing practices or actions that otherwise interfere with timely and accurate claims adjudication, including but not limited to:

- Falsifying documentation or claims
- Allowing another individual or entity to bill using the provider's name
- Billing for services not actually rendered
- Billing for services that cannot be substantiated from written medical records
- Failing to supply information requested for claims adjudication
- Using incorrect billing codes, unlisted codes or multiple codes for a single charge, or upcoding
- Unbundling charges (for the purpose of this manual, unbundling means separating charges for services that are normally covered together under one procedure code or included in other services)

Providing Records for Review

All information required to support the codes and services submitted on the claim is expected to be in the member's medical record and be available for review. 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.

See Reimbursement Policy # RPM039, "Medical Records Documentation Standards."

Records Fees, Copying Fees, etc.

For member plans originating in the state of Texas, reimbursement will be made for providing paper copies of medical records, not to exceed the amount required by current Texas state law. See reimbursement policy RPM005, "Records Fees, Copying Fees."

Records Considered for Review

See Reimbursement Policy RPM039, "Medical Records Documentation Standards." **Note:** this section of the policy is based on The Joint Commission's timeliness standards and Noridian Medicare's "Documentation Guidelines — Amended Records.

Legibility of Records

All records must be legible for purposes of review. When illegible records are received, the services are considered not documented and therefore non billable. This is consistent with legibility standards of both The Joint Commission and Medicare auditors. See Reimbursement Policy RPM039, "Medical Records Documentation Standards."

Amended Medical Records

Late entries, addendums or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record bears the current date of that entry and is signed by the person making the addition or change. Other distinctions and requirements also apply, such as documenting the reason for changes or additions made.

See Reimbursement Policy RPM039, "Medical Records Documentation Standards."

Corrected Claims Following Review for Coding and Documentation Verification

Corrected claims and/or additional codes and charges will not be accepted on claims that have been reviewed against records (coding and documentation verification). The review determination and/or the explanation codes provided can and should be used to correct the underlying documentation and coding problems on all services and claims on a go-forward basis to avoid similar denials in the future. The review determination for a prepayment review will be documented in a claim note; this information can be obtained by contacting Moda Health Customer Service. See also Recovery of Over/Underpayments to Providers section.

Third party liability

Definitions

Third-Party Liability (TPL)

Refers to a situation where another person or company may be responsible or liable for an illness or 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 Moda Health pays claims that are determined to be the responsibility (or liability) of a third party, Moda Health is entitled to assume the member's legal right to collect a portion of the debt or damages resulting from the illness or injury. The exact amount Moda Health can recover is governed by the Texas Civil Practice and Remedies Code, Sec. 140.005. This does not eliminate the patient's right to seek to collect damages above and beyond the amount of the claims paid by Moda Health.

Please note: Self-funded plans may not follow the Texas Civil Practice and Remedies Code, Sec. 140.005.

Is this Third-Party Liability?

Examples of situations that may involve third-party liability:

- 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 pickup, 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 Does Moda Health Handle Possible Third-Party Liability Situations?

When Moda Health has information that third party liability may exist, a Third-Party Reimbursement Questionnaire and Agreement is mailed to the member, and all claim(s) related to the condition will be pended for additional information requested. If a member response is not received within 25 days, the claim(s) are denied, and the investigation is closed until a member response is received.

Moda Health seeks a signed subrogation agreement to help ensure that when a settlement is reached, the money owed to Moda Health for these claims is repaid. The subrogation 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 an insured 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 is aware that an attorney is already representing the patient, the attorney will be contacted. The agreement contains a statement the claimant must sign agreeing to reimburse Moda 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, Moda Health will 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.

Contract Provision

Moda Health contracts generally contain plan wording that includes the following:

- Consistent with the Texas Civil Practice and Remedies Code, section 140.005, we are entitled to be reimbursed for any benefits paid by us that are associated with any illness or injury that are or may be recoverable from a third party or other source. Amounts received by us through these recoveries help reduce the cost of premiums and providing benefits.
- If the covered individual continues to receive medical treatment for an illness or injury after obtaining a settlement or recovery from a third party, we will provide benefits for the continuing treatment of that illness or injury only to the extent that the covered individual can establish that any sums that may have been recovered from the third party for the continuing medical treatment have been exhausted for that purpose.

Moda Health logs and tracks all payments in preparation for the final settlement. Our subrogation department will continue to work with the member and the attorney until the settlement permissible under the Texas Civil Practice and Remedies Code section 140.005 is received and all aspects have been resolved. After a settlement is reached, related claims may be denied by Moda Health as "Patient to pay out of settlement received."

Billing the member

Covered services

Moda Health providers are prohibited from billing the member for any covered services except for copayments, coinsurance, and deductibles.

1. Copayments, coinsurance, and any unpaid portion of a deductible may be collected from the member at the time of service.
2. If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member the overpaid amount within 30 days once the provider determines that an overpayment has been made.

Moda Health assigns 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. When this happens, you may need to refund money back to your patients if you have already collected payments for deductibles.

Since collecting money for deductibles and coinsurance up front and making refunds later adds administrative work for you and causes member dissatisfaction, Moda Health discourages collecting deductibles and coinsurance amounts from our members at the time of service. Your EOP will show if the member has patient responsibility for these amounts at the time your claim is processed.

Non covered services

Contracted providers may only bill Moda Health members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

1. The specific service(s) to be provided
2. A statement that the service is not covered by Moda Health
3. A statement that the member chooses to receive and pay for the specific service
4. The member is not obligated to pay for the service if it is later found that service was covered by Moda Health at the time it was provided, even if Moda Health did not pay the provider for the service because the provider did not comply with Moda Health requirements

Billing for “No-Shows”

Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call in advance to cancel the appointment. The “no show” appointment must be documented in the medical record.

Failure to Obtain Authorization

Providers may not bill members for services when the provider fails to obtain an authorization and the claim is denied by Moda Health.

No Balance Billing

Payments made by Moda Health to providers less any copays, coinsurance, or deductibles which are the financial responsibility of the member, will be considered payment in full. The member may not be balance-billed. That is, providers may not seek payment from Moda Health members for the difference between the billed charges and the contracted rate paid by Moda Health.

Member rights and responsibilities

Member Rights

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 or not the cost or benefit is covered by Moda Health, and the right to refuse care and to be advised of the medical result of their refusal of care.
- 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 provider (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 Moda Health's policy on members' rights and responsibilities.

Member Responsibilities

Members have the responsibility to:

- Read the certificate or policy to make sure they understand the plan. Members are advised to call Moda Health 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.
- 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 from third-party payments they may receive in accordance to Texas Civil Practice and Remedies Code, Sec. 140.005.
- 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 Moda Health Medical Customer Service department.

Provider Rights and Responsibilities

Provider Rights

1. To be treated by their patients, who are Moda Health members, and other healthcare workers with dignity and respect.
2. To receive accurate and complete information and medical histories for members' care.
3. To have their patients, who are Moda Health members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
4. To expect other network providers to act as partners in members' treatment plans.
5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Moda Health and/or a member.
7. To file a complaint on behalf of a member, with the member's consent.
8. To have access to information about Moda Health quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
9. To contact Provider Relations with any questions, comments, or problems.
10. To collaborate with other health care professionals who are involved in the care of members.
11. To not be excluded, penalized, or terminated from participating with Moda Health for having developed or accumulated a substantial number of patients in Moda Health with high cost medical conditions.
12. To collect member copays, coinsurance, and deductibles at the time of the service.
13. To object to providing relevant or medically necessary services on the basis of the provider's own moral or religious beliefs or other similar grounds.

Provider Responsibilities

Providers must comply with each of the items listed below:

1. To help members to make decisions about and to advocate for members when needed regarding their health and healthcare within the provider's scope of practice about their relevant and/or medically necessary care and treatment, including by:
    a. Recommending new or experimental treatments, as available and appropriate.
    b. Providing information to the member regarding the nature of treatment options.

c. Providing information to the member about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered,

d. Informing the member of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.

2. To treat members with fairness, dignity, and respect.
3. To not discriminate against members on the basis of race, color, gender, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care.
4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
7. To allow members to request restriction on the use and disclosure of their personal health information.
8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
9. To provide clear and complete information to members -in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.
10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
12. To respect members' advance directives and include these documents in their medical record.
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
15. To follow all state and federal laws and regulations related to patient care and rights.
16. To participate in Moda Health data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data.

17. To review clinical practice guidelines distributed by Moda Health.
18. To comply with the Moda Health Medical Management program as outlined herein.
19. To disclose overpayments or improper payments to Moda Health.
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
21. To obtain and report to Moda Health information regarding other insurance coverage the member has or may have.
22. To give Moda Health timely, written notice (as outlined in provider contract) if provider is leaving/closing a practice.
23. To contact Moda Health to verify member eligibility and benefits, if appropriate.
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
26. To provide hours of operation to Moda Health members which are no less than those offered to other commercial members.
27. To accurately document all information to support billed services in the medical record in a timely manner before the claim is submitted.
28. Upon request, to provide in a timely fashion, all pertinent information and records needed to support the services billed and/or any related reviews and carrier responsibilities.

Cultural competency

Moda Health views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Moda Health is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

- As part of Moda Health's Cultural Competency Program, providers must inform members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services and ensure that:
- Medical care is provided with consideration of the members' primary language, race ethnicity and culture;
- Office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training;
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the member's perspective on health care;
- An appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Moda Health considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- denying a member a covered service or availability of a facility; and
- providing a Moda Health member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

For additional information regarding resources and trainings, visit:

- The Health and Human Services Commission Center for Elimination of Disproportionality and Disparities, Office of Minority Health and Health Equity online course - txhealthsteps.com/cms/?q=catalog/ course/2188
- "A Physician's Practical Guide to Culturally Competent Care," developed by the U.S. Department of Health and Human Services, Office of Minority Health - cccm.thinkculturalhealth.hhs.gov
- The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) site, hrsa.gov/about/organization/bureaus/ohe/healthliteracy/index.html. Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.

Complaint process

Provider Complaint/Grievance and Appeal Process

In addition to the appeal and complaint rights for adverse determination, Moda Health strives to informally resolve issues on initial contact whenever possible. Before entering the appeals process, please contact Moda Health's Medical Customer Service team at 844-931-1779 for group plans and 844-827-6571 for individual plans. 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.

See Timely Filing Limits for time requirements for each of the steps outlined below.

Reconsideration

The first time a request for review is submitted to the appeals team, it will always be considered a reconsideration. 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. All supporting documentation submitted by the provider will be reviewed, along with the member's benefit plan.

The Moda Health Provider Appeals Unit will review the materials submitted, with a goal of sending written notification of its decision within 120 days of receipt of the inquiry and notification of the provider's right to the next step in the appeal process. When the inquiry results in an overturn of the original decision, the provider will receive a revised EOP. If the provider disagrees with the Moda Health determination in response to the reconsideration, the provider may file a first-level provider appeal.

First-Level Appeal

The appeal will be reviewed by the director of Claims and the Moda Health medical director in accordance with the terms of the contract. Moda 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. When the appeal results in an overturn of the original decision, the provider will receive a revised EOP.

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 Moda Health 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 minimum information:

- The provider's name
- The provider's Tax Identification Number
- Contact name, address, and phone number
- Patient's name
- Moda Health member identification number
- Date of service and claim number or authorization number if no claim
- A copy of the original explanation of payment (EOP) for the claim.
- A detailed description of the reason for the inquiry or appeal, an explanation of what the provider believes is incorrect, and attach supporting medical records or documentation when applicable
- For claims involving coordination of benefits, the name and address of the primary carrier

Mail your inquiry or appeal to:
Moda Health Plan, Inc.
Provider Appeal Unit
P.O. Box 40384
Portland, OR 97240

Member/Provider Complaint and Appeal Process

Please note: Self-funded plans may have a different complaint and appeal process.

Appeals
For insured health benefit plans, member or their authorized representative and their provider on record may appeal an adverse determination. Appeals can be submitted by mail, fax, email, or phone. Providers can appeal regarding medical necessity, prior authorization, and referral issues.
Mail: Appeal Unit, PO Box 40384, Portland, OR 97240
Fax: 866-923-0412
Email: TexasAppealReview@modahealth.com

A member or the authorized representative has 180 days from the date of a notice of an adverse determination to submit an appeal, orally or in writing. Persons not involved in any previous decision will review the appeal. After this review the member has the option to file for an external review.

Receipt of a member appeal is acknowledged by Moda Health in writing within five business days. A written response is sent to the member and the provider on record based on the timelines for different types of appeals. If the claim is related to a life-threatening condition, emergency care, continued hospitalization or denial of prescription medications or intravenous infusions, member or the provider on record may request an expedited appeal. Also, a provider may request a specialty

review, performed by someone who holds the same or similar specialty as would typically manage the case, within 10 days of its denial.

The Moda Health Member Appeal Unit performs a thorough investigation of the appeal. The written response advises the member of the Moda Health 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 request an external review and how to file a complaint with the Texas Department of Insurance.

Additional assistance from the Texas Department of Insurance:

Complaints
Member or their authorized representative and a provider on record may file a written or oral complaint about our utilization review process or procedures. We will respond to your complaint in writing within 30 days.

Additional assistance from the Texas Department of Insurance:
Member or their authorized representative and a provider on record may file a complaint with the Texas Department of Insurance.

Phone: 800-252-3439
Fax: 512-490-1007

Mail: Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

Email: ConsumerProtection@tdi.texas.gov
Internet: tdi.texas.gov

Quality improvement plan

Overview

Program Goal

The goal of Moda Health's Quality Improvement (QI) program is to advance the "triple aim" for our members: improving patient experience, reducing costs, and improving overall health.

Program Objectives

Moda Health QI program objectives are to:

- Establish and maintain organizational systems for ensuring quality and safe healthcare and service delivery;
- Continuously evaluate the quality and safety of healthcare and service delivery provided to members;
- Continuously improve the quality and safety of the care and service delivered to improve the health status of Moda Health members and their communities and to ensure member satisfaction with the experience of care.
- Ensure the delivery of cost-effective care and services;
- Promote communication between the organization and its practitioners and members;
- Partner with practitioners to improve the quality and safety of medical care in their clinical practices;
- Assure quality and accountability through measurement of performance and utilization;
- Participate in initiatives that improve healthcare for all Oregonians by:
    - Supporting community, state and national health initiatives
    - Building partnerships with other healthcare organizations
    - Seeking collaborations to identify and eliminate healthcare disparities

As a means to achieve these QI program objectives, Moda Health requires practitioner participation in data sharing, medical record reviews, investigation of complaints, outcomes studies and data collection from monitoring and evaluation of health care service and delivery for members. This collaboration allows Moda Health to focus on QI projects that have a significant impact on the health of plan members and have measurable outcomes for quality of life and/or health resources utilization. We select QI projects based on a number of factors, including acuity, high volume, high cost, high outcomes variance, population-based healthcare standards (such as preventive services, early diagnosis and appropriate therapies), patient safety, member satisfaction levels and available resources.

QI Committee Structure

The Medical Quality Improvement Committee (MQIC) has operational authority and responsibility for the Moda Health QI program. It reviews and evaluates the quality of healthcare and services provided to Moda Health members, develops quality improvement initiatives and interventions to improve care and service to members and recommends policy decisions that affect the quality of healthcare and services provided to Moda Health members. The MQIC reports to the Moda Health

Policy Committee of the Moda Health Board of Directors. Moda Health will conduct quality assessment through a panel of at least three physicians selected from among our list of contracted physicians.

Scope of Service and Issues Reviewed
The MQIC defines an annual QI work plan of quality improvement and quality assurance projects and activities. These include the monitoring and measuring of clinical care, quality of service, member experience and patient safety as well as regulatory requirements, including external quality review activities, for which Moda Health ensures access to medical records, information systems, personnel and documentation requested by the external quality review organization.

The following list encompasses the settings in which Moda Health members receive care and services delivered by our network providers:

- Hospitals
- Urgent care centers
- Ambulatory surgery centers
- Home healthcare services
- Consultation services
- Vision clinics
- Dialysis centers
- Hospices
- Skilled nursing facilities
- Drug and alcohol dependency facilities

Providers are Primary Care Providers and Specialists, as well as Behavioral Health Providers who offer chemical dependency treatment and mental health services. All Network Providers are included in Moda Health's QI program, which includes but is not limited to:

- Outcomes of care
- Utilization of services
- Selected Healthcare Effectiveness Data Information Set (HEDIS) indicators
- Access to care
- Member experience and satisfaction
- Patient Safety
- Compliance with government regulations

Moda Health considers and treats any member or provider specific data in accordance with the organization's privacy and confidentiality policy.

Moda Health prepares an annual evaluation of the QI program that is presented to the MQIC and reported to the Moda Health Policy Committee. The evaluation is the basis upon which Moda Health develops the following year's QI work plan.

Quality Rating System

Healthcare Effectiveness Data and Information Set (HEDIS) HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. Purchasers of health care may use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate the clinical management of its members. Physician-specific scores are being used as evidence of preventive care from primary care office practices.

HEDIS Rate Calculations

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and behavioral health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10,and HCPCS codes can reduce the necessity of medical record reviews. HEDIS measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c values, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

How can providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Moda Health. Claims and encounter data is the most clean and efficient way to report HEDIS.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record documentation of each member service, and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure, where appropriate. If you have any questions, comments, or concerns related to the annual HEDIS project or medical record reviews, please contact the Quality Improvement Department at 1-877-684-1169.

Regulatory matters

Medical Records

Moda Health providers must keep accurate and complete patient medical records which are consistent with 45 CFR 156, financial, and other records pertinent to Moda Health members. Such records enable providers to render the most appropriate level of health care service to members. They will also enable Moda Health to review the level and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Moda Health requires providers to maintain all records for members for at least 10 years after the final date of service, unless a longer period is required by applicable state law.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations and signed by the medical professional rendering the services. Providers must maintain complete medical records for members in accordance with the standards set forth below:

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Moda Health practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.

- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant members or infant risk assessment for newborns.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented, including follow up of outcomes and summaries of treatment rendered elsewhere, including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Access to Records and Audits by Moda Health

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Moda Health or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by Moda Health or its designated representative, but not more than sixty (60) days following such written notice.

EMR Access

Providers will grant Moda Health access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the Moda Health for this access.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis. All release of specific clinical or medical records for substance use disorders must meet Federal guidelines at 42 CFR Part 2 and any applicable State Laws.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Moda Health members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Federal And State Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, behavioral health, alcohol /substance abuse treatment, and communicable disease records.

For example, HIPAA requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as behavioral health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: cms.hhs.gov, and then select "Regulations and Guidance" and "HIPAA – General Information;"
- 42 CFR Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: samhsa.gov;
- State laws - see Texas Insurance Code Section 601, 28 Texas Administrative Code chapter 22.

Contracted providers within the Moda Health network are independently obligated to know, understand, and comply with these laws.

Moda Health takes privacy and confidentiality seriously. We have established processes, policies, and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws. Please contact the Moda Health Privacy Office by phone at 1-855-425-4192 or in writing (refer to address below) with any questions about our privacy practices.

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

For more information please visit hhs.gov/civil-rights/for-individuals/section-1557/index.html

Fraud, waste and abuse

Our Special Investigations Unit responds to fraud, waste and abuse issues. It is also responsible for:

- Conducting desk audits
- Conducting on-site audits
- Investigation of possible fraudulent and/or abusive billing practices
- Providing fraud training to internal and external entities alike
- Responding to complaints from members and providers that call our fraud hotline at 855-801-2991

The following are examples of fraudulent, abusive or inappropriate billing for services. Included are common violations of provider contracts.

- Billing separately for services included within a global period.
- Reporting excessive costs.
- Billing for telephone calls.
- Advertising free or discounted services, then billing for additional services that may or may not be medically necessary.
- Billing for services not rendered, not medically necessary or in a manner that overstated the service rendered.
- Billing for services provided by another provider, practitioner or laboratory (except where a written agreement allows this).
- Billing for services or treatment performed on a family member, even those with different last names (a family member is defined as the providers spouse, parent, child or eligible dependent).
- Submitting claims for charges, that in the absence of member insurance, there would be no obligation to pay. It is inappropriate to bill for services that, in the absence of insurance coverage, would be a professional courtesy.
- Billing cosmetic procedures (any procedure that is requested for the purpose of improving or changing appearance without restoring impaired body function) as medically necessary.
- Unbundling charges (for purposes of this agreement, unbundling means separating charges for services that are normally covered together under one procedure code or included in other services).
- Billing for experimental and investigational services.
- Billing for services that cannot be substantiated from medical records.
- Falsifying documentation or claims.
- Cloned claims.

Definitions

Fraud — Is conduct that involves intentional deception or misrepresentation, knowingly making a false claim, or other intentional or willful deception or misrepresentation, known to be false or otherwise unlawful or improper, in order to receive some unauthorized benefit.

Knowing — Can mean actual knowledge or acting with reckless disregard or deliberate ignorance of truth or falsity. Inadvertent errors, such as occasionally reporting the wrong billing code, are not considered fraudulent.

Abuse — An activity or practice undertaken by a member, practitioner, employee, or contractor that is inconsistent with sound fiscal, business or medical/dental practices and results in unnecessary cost to Moda Health, reimbursement for services that are not medically necessary, or fails to meet professionally recognized standards for health care.

Waste — The extravagant, careless, or unnecessary utilization of or payment for health care services.

Investigations
The Special Investigations Unit (SIU) may conduct audits of providers during providers' regular business hours. The SIU will provide a provider 10 business days or a lesser, mutually-agreed-upon advance notice of such an audit, except when Moda Health, in its discretion, determines there is a significant quality-of-care issue or risk that the provider's documents may be altered, created or destroyed. In a such case, the provider will provide Moda Health access to the facility or records upon 24 hours' notice. All medical records shall include dates of service, member's name, diagnosis, description of services provided, any supporting documentation, medical and billing records and identity of the practitioner providing the services.

Where not specifically stated in guidelines or policy, Moda Health follows Centers for Medicare and Medicaid Services guidelines and MCG (formerly Milliman Care guidelines). Records not produced at the time of the audit will be deemed nonexistent. The provider shall be responsible for the cost of copying any records photocopied during an on-site audit. This is considered a cost of doing business. However, most records are scanned using secure encrypted means.

Audits shall be conducted in a manner that, to the greatest extent possible, avoids disruption of provider's business affairs and minimizes the burden on the provider. Audits will comply with all laws, statutes and regulations pertaining to the confidentiality of member records. Failure by the provider to cooperate with the audit will be a breach of this agreement. These rights shall survive termination of this agreement.

When our Special Investigations Unit investigates possible fraud and/or abuse issues, we have the authority to retrospectively review and demand reimbursement of overpayments up to a 24-month period. In cases of proven fraud, there is no retrospective time or monetary limit.

Desk Audits
As a participating provider with Moda Health, we reserve the right to randomly conduct desk audits.

Member Card Fraud
Member card fraud is on the rise, many cases of medical identity theft are reported involving member cards that are stolen, misplaced or "loaned" to family members or acquaintances. Theft can also occur when a member's information is presented by someone else at their time of service.

When member card fraud is discovered, we will seek reimbursement from the person or persons committing the fraud. However, if a provider is found negligent in gathering proper information and identification, the provider may be held responsible for restitution.

Special Investigations Unit Appeal Process
The Special Investigations appeal process is intended to give you an opportunity to request reconsideration of review findings issued by the Special Investigations Unit and to ensure we have reviewed all information relevant to the review findings. Please note that contract terminations resulting from review findings will follow the provider contract termination appeal process.

Request for Reconsideration
You may request a reconsideration of our review findings by submitting a written request for a reconsideration of review findings. The address to send your reconsideration request is listed on your review findings.

The reconsideration request must be received by Moda Health within 45 business days of your receipt of the review findings and must include, at a minimum, the following:

- A detailed statement of the issue(s) in dispute
- At the discretion of the provider, notification of a request for a meeting with the board reviewing the issue(s) in dispute
- Any document that the provider contends supports their position. (Exception: Additional documentation required to justify your billing that was not present at the time of the initial review, including but not limited to chart notes, will not be considered in connection with an appeal involving adverse review findings. We will, however consider your explanation as to why the documentation was not present at the time of the review.)

If we do not receive a reconsideration request within 45 business days of your receipt of the review findings, the findings will be final.

The request for reconsideration will be reviewed by the Special Investigations Unit and other Moda Health representatives with relevant expertise, given the subject matter (hereafter referred to as the “board”). At the discretion of the board, a Moda Health medical director may be consulted prior to the final decision.

Prior to the board’s review of your request for reconsideration, you may request a meeting either at your office or a Moda Health office, as mutually convenient. You must request this meeting when submitting your request for reconsideration.

At such a meeting, you may appear in person and be accompanied by an attorney or other representative. You and your representative may make an oral statement to the board. The purpose of this meeting is to give you an opportunity to present your position to the board in person. You may be asked to respond to questions from the board.

The board will notify you if additional documentation is required for the board to reach a decision. Such additional documentation must be submitted within 10 business days of the date of the written request for information.

- If the requested documentation is received on time, it will be included in the request for reconsideration.
- If the requested documentation is not received on time, the request for reconsideration will continue in the absence of such documentation, and a decision will be made based on the information originally submitted.

You will be sent written notice of the decision within 45 business days following the meeting with the board. If no such meeting was requested, you will be sent written notice of the decision within 45 business days of our receipt of the review reconsideration request. If additional documentation is requested by the board, as provided above, the timelines for issuing a decision shall commence as of the date of the board's receipt of such additional information.

The decision on a review reconsideration request is deemed final 45 business days after your receipt of the board's decision, unless a timely written request for a medical director review is received, as set forth herein.

Medical Director Review

If you are not satisfied with the decision made following the reconsideration request to the board, you may request a medical director review of the Special Investigations Unit review findings. The written request for a medical director review and any supporting information must be received by Moda Health within 45 business days of your receipt of the board's decision. The address to send your request for medical director review will be included in our response to your request for reconsideration.

The medical director review will be held no more than 45 business days following receipt of the request, not including the time in which Moda Health is waiting for additional information from you. The review will be conducted by a medical director who was not involved in an earlier review of the findings.

If the Medical Director needs additional documentation to reach a decision, the additional documentation must be submitted within ten (10) business days of the date of the written request for information, unless a written request for a reasonable extension of time is granted.

- If the requested documentation is received on time, it will be included in the Medical Director Review.
- If the documentation is not received on time, the Medical Director Review will continue and a decision will be made based on the information originally submitted.

During the period of time in which Moda Health is waiting for additional information, the forty-five (45) business day timeline to complete the Medical Director Review shall be suspended until the information is received or the time to respond to the request has expired.
You will be sent written notice of the decision within forty-five (45) business days following the medical director review.

The medical director review is the final step in the Special Investigations Unit appeal process. Once a decision has been made by the medical director, the Special Investigations Unit appeal process has been completed and the decision shall be deemed final. If you are not satisfied with the Moda decision after completing the Special Investigations appeal process and want to continue to dispute the issue(s), you must initiate the appropriate appeal process(es) as outlined in your provider contract.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the Federal government. The Act prohibits:

1. knowingly presenting, or causing to be presented a false claim for payment or approval;
2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. conspiring to commit any violation of the False Claims Act;
4. falsely certifying the type or amount of property to be used by the Government;
5. certifying receipt of property on a document without completely knowing that the information is true;
6. knowingly buying Government property from an unauthorized officer of the Government; and
7. knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims act, please visit cms.hhs.gov.

Physician Incentive Programs

On an annual basis and in accordance with Federal Regulations, Moda Health must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- effective date of the Physician Incentive Program
- type of Incentive Arrangement
- amount and type of stop-loss protection
- patient panel size
- description of the pooling method, if applicable
- for capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral, and other services
- the calculation of substantial financial risk (SFR)
- whether Moda Health does or does not have a Physician Incentive Program
- the name, address, and other contact information of the person at Moda Health who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stop-loss protection, member satisfaction surveys, and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold, which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR. If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Relations Representative.

Appendix A - 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.

Administrative Services Only (ASO) — An arrangement between an employer and a separate third-party organization, frequently an insurance company, where the third party provides administrative services (such as the processing of medical claims or communication of benefits to employees) to the employer's workers. The employer is responsible for paying the cost of the healthcare service provided. This is a common arrangement when an employer pays for all healthcare treatment directly (self-insured) and needs a separate organization to handle the administrative paperwork and management.

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

Ancillary Services — Support services provided to a patient in the course of care. They include such services as laboratory and radiology.

Appeal — A specific request to reverse a denial or adverse determination and potential restriction of benefit reimbursement.

Applicable Law(s) – All federal and state laws and regulations that are applicable to any provisions of this Agreement, including without limiting the foregoing, the State insurance code.

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 their behalf directly to the physician or other provider of that service.

Audit — A procedure authorized by Texas Insurance Codes under which a carrier may investigate a claim beyond the statutory claims payment period without incurring penalties under 28 TAC §21.2815 (relating to Failure to Meet the Statutory Claims Payment Period).

Authorization or Authorized Services — A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.

Batch Submission — A group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.

Benefit Package — A collection of specific services and treatments a member may receive under the terms of his or her individual insurance policy or group policy through an employer.

Benefit Tracker — A free online service offered to providers. Available via Benefit Tracker is access to: member eligibility, network information, copayment and deductible Information, PCP information, claim status and referral status. Online referral entry is limited to PCPs.

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.

Carrier — A commercial enterprise, licensed in a state to sell insurance.

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

Catastrophic Event — An event, including an act of God, civil or military authority, or public enemy; war, accident, fire, explosion, earthquake, windstorm, flood, or organized labor stoppage, that cannot reasonably be controlled or avoided and that causes an interruption in the claims submission or processing activities of an entity for more than two consecutive business days.

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.

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(s) – A claim that is submitted on an industry standard form (CMS 1500, UB-04 or successor form) including electronic equivalent, complies with all billing guidelines and requirements, has no defects or improprieties, includes all documentation and medical records needed for adjudication, and does not require special processing that would prevent timely payment. See Page 24 for the definition of clean claims under Texas Insurance Codes. This provision does not apply to self-funded plans.

Clearinghouse — An intermediary that accepts electronic transmissions from other organizations, edits and processes the 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 — Moda Health employs clinical edits in the processing of medical claims. Our clinical edit set focuses on correct coding methodologies and accurate, appropriate adjudication of claims.

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 Medicare by individual healthcare practitioners (formerly HCFA 1500).

Coinsurance — An insurance arrangement stipulating that the member is responsible for paying a specific percentage of any medical bills.

Complaint — An oral or written expression of dissatisfaction about the utilization review process. A complaint does not include a request for information or clarification about any subject related to this Policy. A complaint involving an adverse determination is an appeal of that adverse determination.

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.

Continuity of Care — A feature of a health benefit plan that allows a member to continue to receive care from a provider for a limited time after the medical service contract between Moda Health and the provider terminates.

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 health plan.

Copayment — The fixed dollar amounts or percentages of covered expenses to be paid by the eligible member.

Corrected Claim — A claim containing clarifying or additional information necessary to correct a previously submitted claim.

Cost Sharing — A general set of financing arrangements via deductibles, copayments and/or co-insurance where a member must pay some of the cost of their healthcare services.

Coverage Agreement(s) – Any agreement, program or certificate entered into, issued or agreed to by Moda Health and the Payer, under which Moda Health furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Moda Health's provider networks or vendor arrangements, except those excluded by the Payer's Health Plan.

Covered Person(s) – Any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

Covered Services — Medically necessary healthcare services covered under a health benefit plan, as determined under the terms and conditions of the applicable health benefit plan.

Credentialing — The process of determining if a new practitioner can join the Moda Health provider panel. 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 Contact — The person who submitted the application on behalf of the provider.

Current Procedural Terminology (CPT) — The coding system for physician 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 portion of an individual's healthcare expenses that must be paid by the member in a given year before the health plan will start paying for treatment.

Delegated Entity — An IPA, medical group, clinic, third-party panel or Credentialing Verification Organization(CVO) that is delegated the responsibility of credentialing its providers for Moda Health.

Dependents — Members covered through a health plan other than the subscriber — for instance, the subscriber's spouse and/or children.

Designee(s) — A person who has been designated to perform some duty or carry out some specific role.

Diagnosis Codes — 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-CM codes, Diagnostic and Statistical Manual (DSM-V) or their successors, valid at the time of service, are referred to as diagnosis codes.

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 — Billed charges that the health insurance carrier 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.

Duplicate Claim — Any claim submitted by a physician or a provider for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim. The term does not include corrected claims or claims submitted by a provider at the request of the carrier.

Effective Date — The date a contract or policy 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 a payment disbursement register (PDR).

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

Eligibility Date — The defined date an individual becomes eligible for benefits under an existing contract.

Emergency Care – Healthcare services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

1. placing the person's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of a bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Medical Condition — A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency Medical Screening Examination — The medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency Services — Healthcare items and services furnished in an emergency department and all ancillary services routinely available, and within the capabilities of the staff and facilities available at the hospital, such that further medical examination and treatment are required to stabilize a member.

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.

Enrollee(s) – Interchangeable with Subscriber: The individual enrolled for coverage under an individual health benefit plan or the individual whose employment is the basis for eligibility in a group Health Plan.

Enrollment Date — For new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

Exclusion Period — A period during which specified treatments or services are excluded from coverage.

Exclusions — Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide coverage or reimbursement.

Explanation of Benefits (EOB) — The statement sent to subscribers by their health plan (health carrier 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 payer may use an electronic remittance advice (ERA) to advise providers.

Federal Law – The body of law consisting of the U.S. Constitution, federal statutes and regulations, U.S. treaties, and federal common law. The Federal law is the supreme law in US and overrides state law whenever there is a conflict.

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.

Group — The organization whose employees are covered by a health plan.

Healthcare Financing Administration (HCFA) — See Centers for Medicare and Medicaid Services (CMS).

Health Benefit Plan — A plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by an insurance company, a group hospital service corporation, a fraternal benefit society, a stipulated premium insurance company, a health maintenance organization, a multiple-employer welfare arrangement, or other benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

Health Care Provider – A physician or health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Services – The furnishing of medicine, medical or surgical treatment, nursing, hospital service, dental service, optometrical service, complementary health services or any or all of the enumerated services or any other necessary services of like character, whether or not contingent upon sickness or personal injury, as well as the furnishing to any person of any and all other services and goods for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury.

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 should 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) — A uniform method for healthcare providers and medical suppliers to report professional services, procedures and supplies. HCPCS codes are five-digit codes; the first digit is a letter that is followed by four numbers. Codes beginning with A through V are national; those beginning with W through Z are local.

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

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

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.

Individual Provider – A certified health care professional who provides medical services through a medical group, health care system, or individual medical practice.

Individual Location – A single practice location that a provider has contracted with in order to provide medical care to Health Plan members.

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

In-Network Provider(s) – Provider of health care services that has a managed care agreement with Moda Health or another Moda Health base plan.

In-Network Services(s) – Covered Services provided to Subscribers by an In-Network Provider or are provided in accordance with the Health Plan's requirements for in-network benefits.

International Classification of Diseases (ICD) — A set of codes which is the international health information standard for defining and reporting diseases and health conditions. The 10th version (ICD-10) is currently in use. The ICD code set is comprised of two distinct sets of codes, diagnosis codes (ICD-10-CM) and hospital inpatient procedure codes (ICD-10-PCS).

Law(s) of the State – Refers to the law of each separate U.S. state.

Material Litigation – Any litigation that, according to generally accepted accounting principles, is deemed significant to an applicant's or licensee's financial health and would be required to be referenced in the applicant's or licensee's annual audited financial statements, report to shareholders or similar documents.

Maximum Plan Allowance (MPA) — The maximum amount that Moda Health will reimburse providers. For a participating provider, the maximum amount is the contracted fee.
MPA for an out-of-network provider is either a supplemental provider fee arrangement Moda Health may have in place or the amount calculated using one of the following methodologies, any of which may be used: a percentage of the Medicare allowable amount, a percentile of fees commonly charged for a given procedure in a given area, a percentage of the acquisition cost or a percentage of the billed charge. Otherwise, the MPA is the amount determined by state guidelines.

- MPA for emergency services received out-of-network is the greatest of the median in-network rate, the maximum amount as calculated according to this definition for out-of-network facility and the Medicare allowable amount.
- MPA for prescription medications at out-of-network pharmacies is no more than the prevailing pharmacy network fee based on the average wholesale price (AWP) minus a percentage discount.

In certain instances, when a dollar value is not available, Moda Health reviews the claim to determine a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

Medically Necessary — Healthcare services, medications, supplies or interventions that a treating licensed healthcare provider recommends and all of the following are met:

- It is consistent with the symptoms or diagnosis of a member's condition and appropriate considering the potential benefit and harm to the patient;
- The service, medication, supply or intervention is known to be effective in improving health outcomes; and
- The service, medication, supply or intervention is cost-effective compared to the alternative intervention, including no intervention.

Medically necessary care does not include custodial care.

Note: The fact that a provider prescribes, orders, recommends or approves a service or supply does not, of itself, make the service medically necessary or a covered service.
Moda Health may require proof that services, interventions, supplies or medications (including court-ordered care) are medically necessary. No benefits will be provided if the proof is not received or is not acceptable, or if the service, supply, medication or medication dose is not medically necessary. Claims processing may be delayed if proof of medical necessity is required but not provided by the health service provider.
Moda Health uses scientific evidence from peer-reviewed medical literature to determine effectiveness for services and interventions for the medical condition and patient indications being considered.

Member — Any individual who is eligible to receive Covered Services under a Health Plan unless otherwise specified by Moda Health. The Subscriber and any dependents are all Members.

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.

Moda Health — Multi-faceted organization with a full line of affordable health plans.

Moda Health Behavioral Health — Provides managed behavioral healthcare services to individuals covered by Moda Health exclusive and preferred provider plans.

National Committee for Quality Assurance (NCQA) — NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.

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

Never Event – Errors in medical care that are clearly identifiable, largely preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Never events include Hospital Acquired Conditions and Serious Reportable Events. Examples of such include surgery on the wrong body part; foreign body left in a patient after surgery; mismatched blood transfusion; major medication error; severe "pressure ulcer" acquired at Provider's facility; and preventable post-operative deaths.

Non-Covered Services – Those health care services, equipment and supplies that are determined by Moda not to be Covered Services in effect at the time Contracted Services are rendered.

Non-Participating and Non-PPO — Hospitals, physicians, providers, professionals and facilities that have not contracted with Moda Health to provide benefits to persons covered under this plan. They will be reimbursed at the maximum plan allowance for the service provided.

Out-of-Network (OON) — When a member receives medical care using a provider not in the specified network that is assigned to their medical plan. Generally, the member will pay a higher cost for services when they receive care out of network, and some plans (such as managed care) do not have out-of-network benefits.

Out of Network Provider(s) – Provider of health care services that is not an In-Network Provider.

Out-of-Pocket (OOP) — The amount a member pays for services, which includes deductibles, copays and coinsurance. Certain expenses such as non-essential health benefits may not accumulate to a plan's out-of-pocket maximum.

Part A (Medicare) — The hospital insurance program, which covers the cost of hospital and related post-hospital services. As an entitlement program, it is available without payment of a premium.

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.

Part D (Medicare) — The first comprehensive drug benefit for seniors and people with disabilities offered under the Medicare program. Beneficiaries may elect a Part D plan if they are eligible for Medicare Part A or Part B. Beneficiaries may also apply for assistance in paying their Part D premiums.

Participating Provider(s) – A licensed facility or licensed, registered, or certified health care professional that agrees to provide health care services to Members and has contracted, directly or indirectly, with Moda Health for participation in the provider network which applies to a specific member's plan.

Participating Provider Directory –A listing of providers and medical organizations that have been approved by Moda Health for network participation.

Participation Criteria – Minimum legal and professional standards that must be verified and maintained, for the duration of this agreement, in order to provide medical services to Health Plan members.
Patient Responsibility — The amount the patient is responsible to pay for the services received. This amount includes disallowed charges, deductibles and copayments.

Payer(s) – An entity other than Moda Health that is financially responsible for payment for Covered Services under a Health Plan.

Person(s) – An individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, government, governmental subdivision, agency or instrumentality, public corporation or any other legal or commercial entity

Plan — The agreement between the policyholder and Moda Health Plan, Inc., which contains all the healthcare benefits and conditions of the plan.

Plan Type(s) – A category of Health Plan products that have a specific network type or set of defined benefits.

Policies and Procedures – Designed to influence and determine all major decisions and actions, and all activities take place within the boundaries set by them. Procedures are the specific methods employed to express policies in action in day-to-day operations of the organization.

Policyholder — The plan sponsor or employer for a group plan; the subscriber for an individual plan.

Primary Care Provider (PCP) — A participating provider who is either a family physician, pediatrician or internist, and whose billings for primary care services are at least 50 percent of the provider's total billings. With respect to women patients, the primary care physician may be a women's healthcare provider, defined as an obstetrician or gynecologist, physician assistant specializing in women's healthcare, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.

Prior Authorization — A request to the health carrier for approval of benefits prior to treatment. Hospitals and certain medications are some of the types of services requiring prior authorization. Failure to receive prior authorization can result in reduced or denied benefits.

Prior Authorization List — A listing of services requiring authorization for all exclusive and preferred health plans.

Private HealthCare Systems (PHCS) — The PHCS Network is the largest proprietary PPO network in the country. As a proprietary network, they contract directly with every provider participating in the network.

Product(s) – Any program or health benefit arrangement designated as a "product" by Health Plan (e.g. Health Plan Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered

by or available from or through Moda Health(and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

Product Category – Type of product or service.

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 that acts as a liaison between Moda Health and providers' offices. Provider Relations is responsible for provider education, identifying trending claim issues, maintaining provider relationships and maintenance of provider demographic information and online directories.

Provider — An individual or facility, engaged in the delivery of health care services, licensed or certified by the State to engage in that activity in the State (if such licensing or certification is required by State law or regulation), and performing within the scope of that license. A provider may be a sole practitioner or is an owner, member, shareholder, partner, or employee of a partnership or professional corporation.

Provider Directory — A listing of all the providers and facilities that are participating with a health plan and network.

Provider Discount — The amount of money a member saves on a service by using a participating provider.

Provider Location(s) – Practice locations that a provider has contracted with in order to provide medical care to Health Plan members.

Participating Provider Administrative Manual — The manual containing information and instructions for providers, which is prepared by Moda Health and may be revised by Moda Health from time to time.

Provider Network(s) – A list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care to its members. These providers are called "network providers" or "in-network providers."

Recredentialing — The process completed at least every three years for the purpose of determining a provider's continuing participation on the Moda Health provider panel. It consists of verifying, through primary sources or NCQA- approved sources, specific elements of the provider's recredentialing application, member complaints, potential and confirmed adverse outcomes, access and after hours coverage, medical record audits and site visits.

Referral — The basis for authorization from a PCP, which allows members to receive care from a different physician or facility. The referral does not guarantee benefits.

Referral Physician — A participating provider (including specialist and primary care physician) who provides medical service to members upon a referral from a primary care physician.

Repayment or Refund – Payments made by a Provider to Moda Health, or Payer, in the event that Moda Health, or Payer, determines an overpayment has been made to a Provider for past services rendered.

Service Area(s) – The area where a Health Plan accepts members. For plans that require members to use their doctors and hospitals, it is also the area where services are provided. The plan may dis-enroll a member if they move out of the plan's service area.

Sub-Contractor(s) – A person who contracts with a contractor or another subcontractor on predetermined terms to be responsible for the performance of all or part of a contractor's job in accordance with established specifications or plans.

Subscriber(s) – Interchangeable with Enrollee. The individual enrolled for coverage under an individual health benefit plan or the individual whose employment is the basis for eligibility in a group Health Plan. The subscriber can enroll dependents under family coverage, if available. The Subscriber and any dependents are all Members.

Subrogation — A provision in the plan that entitles a carrier to recover the amount of benefits paid toward an illness or injury relating to the proceeds of any recovery that is or may be made by a member against a third party or other source.

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.

Texas Standard Prior Authorization Request Form for Health Care Services — A form for prior authorization of a health care services and health benefit plan issuers must accept this form.

Texas Standard Prior Authorization Request Form for Prescription Drug Benefits — A form for prior authorization of a prescription drug or device, and health benefit plan issuers must accept this form.

Texas Standardized Credentialing Application — A standardized form adopted by the Texas Department of Insurance for verification of physician credentials. Use of the application form by hospitals, HMOs and PPOs is required for credentialing of physicians. Hospitals and health plans may use this application for the credentialing of other health care professionals as well.

Third-Party Administrator (TPA) — An independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk.

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.

Urgent Care — The provision of immediate, short-term medical care for minor but urgent medical conditions that do not pose a significant threat to life or health at the time the services are rendered.

UM Program – The policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization. These policies are included in the Provider Manual and are consistent with applicable law, regulation, national standards and guidelines.

Utilization Management (UM) – Programs, procedures and standards established by Payer under which the utilization of care, treatment or supplies may be evaluated against clinical criteria for Medical Necessity.

Utilization Review — The process of reviewing services after they are rendered to ensure that they were medically necessary and appropriate with regard to widely accepted standards of good medical practice.

Women's Healthcare Provider —A participating obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specializing in women's health, certified midwife or nurse practitioner, or certified nurse midwife practicing within the applicable lawful scope of practice.

Appendix B - Acronyms

Acronym	Definition
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

Acronym	Definition
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
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
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 Recredentialing 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
PDR	Payment Disbursement Register
PEPM	Per Employee Per Month
PHCS	Private HealthCare 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
UB-92	Uniform Billing Code of 1992
YTD	Year to Date

Appendix C - Instruction to Complete the CMS1500 form

Field #	Field Name	Instructions — * = Required (also indicated in bold type) — All other required as applicable
1	MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER	Indicate the type of health insurance coverage applicable to this claim by placing and "X" in the appropriate box. Only one box can be marked.
***1A**	**Insured's ID Number**	**Enter the insured's ID number exactly as shown on the insured's ID card.**
***2**	**Patient's Name**	**Enter the patient's last name, first name and middle initial (if known) exactly as it appears on the ID card.**
***3**	**Patient's Birth Date and Sex**	**Enter the patient's eight-digit date of birth in (MM/DD/CCYY) format.** **Place an "X" in the appropriate box to indicate the patient's sex.**
***4**	**Insured's Name**	**Enter the insured's last name, first name and middle initial (if known) exactly as it appears on the ID card.**
***5**	**Patient's Address**	**Enter the patient's address, city, state, ZIP code and phone number (if known). Use two-digit state code.**
6	Patient Relationship To Insured	Enter an "X" in the correct box to indicate the patient's relationship to insured, self, spouse, child or other. Only one box can be checked.
7	Insured's Address	Complete if the patient is not the insured. Enter the insured's address, city, state, ZIP code and phone number (if known). Use two-digit state code. *Note for Worker's Compensation — use address of employer*.

Field #	Field Name	Instructions — * = Required (also indicated in bold type) — All other required as applicable
8	Patient Status	Enter "X" in the box for the patient's marital status, and for the patient's employment or student status. Only one box can be marked. If the patient is a full-time student, please complete 11B if the information is available.
9	Other Insured's Name	When additional group health coverage exists, enter other insured's last name, first name and middle initial (if known). *Enter the employee's group health insurance information for Worker's Compensation*.
9A	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured as indicted.
9B	Other Insured's Date of Birth Sex	Enter the other insured's eight-digit date of birth in (MM/DD/CCYY) format (if known). Place an "X" in the appropriate box to indicate other insured's sex. Only one box can be checked — leave blank if gender is unknown.
9C	Employer's Name or School Name	Enter the complete name of the other insured's employer or school.
9D	Insurance Plan Name or Program Name	Enter the name of the other insured's plan or program name.
***10A-C**	**Is patient's condition related to: Employment (current or previous)? Auto Accident? Other Accident?**	**Only one box can be marked per category, per submission. Place an "X" in the appropriate box. If "yes," complete field 14. Place an "X" in the appropriate box. If "yes," indicate state and complete field 14. Place an "X" in the appropriate box. If "yes," complete field 14**

10D	Reserved for local use	Leave blank
***11**	**Insured's Policy group or FECA number**	**Enter the insured's policy or group number exactly as it appears on the ID card if present. *For Worker's Compensation, enter the Worker's Compensation payer claim number if available.***
11A	Insured's Date of Birth Sex	Enter the insured's date of birth (if known) in (MM/DD/CCYY) format. Place an "X" in the appropriate box to indicate insured's sex. Only one box can be checked — leave blank if gender is unknown.
11B	Employer's Name or School Name	Enter the complete name of the insured's employer or school.
11C	Insurance Plan Name or Program Name	Enter the name of the insured's plan or program name.
11D	Is there another health plan?	Place an "X" in the appropriate box. If "yes," complete fields 9A through 9D.
12	Patient's or Authorized Person's Signature	Enter "Signature on file," "SOF" or legal signature. When legal signature, enter date signed. If there is no signature on file, leave blank or enter "No signature on file."
***14**	**Date of Current Illness, Injury or Pregnancy**	**Enter the first date in eight-digit (MM|DD|CCYY) format of the current illness, injury or pregnancy. For pregnancy, use the date of LMP as the first date.**
15	If patient has had same or similar illness, give first date.	Enter the first date in eight-digit (MM|DD|CCYY) format that the patient had the same or similar illness. Previous pregnancies are not a similar illness. Leave blank if unknown.

16	Date Patient Unable To Work in Current Occupation	Enter dates patient is unable to work in eight-digit (MM|DD|CCYY) format. Leave blank if unknown.
17	Name of Ordering, Referring or Supervising Physician or Other Source	Enter the name of the physician or other source that referred the patient to the billing provider or ordered the test(s) or item(s). If the service is not the result of a referral, enter the performing physician's name. Use the last name and first name (as much as will fit). To the left of the dotted vertical line, enter one of the following qualifiers as appropriate to identify the role that this physician (or nonphysician practitioner) is performing: Qualifier — Provider Role DN — Referring provider DK — Ordering provider DQ — Supervising provider
17A	Other ID	Enter the Medicare-assigned unique physician identification number (UPIN) of the physician listed in box 17.
17B	NPI	Enter the ten-digit NPI.
18	Hospitalization Dates Related to Current Service	Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred) in eight-digit (MM|DD|CCYY) format. If not discharged, leave discharge date blank.
19	Reserve for Local Use	Leave Blank
20	Outside Lab $ charges?	If patient had lab work done, check the correct box regardless of whether or not you are actually billing for the lab work. You do not need to list charges in this block.
***21**	**Diagnosis or Nature of Illness of Injury**	**List up to four ICD-10-CM diagnosis codes. List in order of relevance. Use the highest level of specificity. Do not provider narrative description in this box. Nonspecific diagnosis, such as 780, may result in your claim being denied.**

22	Medicaid Resubmission	Leave Blank
23	Prior Authorization Number	Leave Blank
***24A**	**Date(s) of Service**	**Enter the dates of service in (MM|DD|YY) format. If one date of service only, enter that date under "From." Leave To blank or re-enter "From" date. If grouping services, the place of service, procedure code, charge and rendering provider for each line must be identical for that service line. Grouping is allowed only if the number of days matches the number of units in 24G.**
***24B**	**Place of Service**	**Indicate where the services were provided by entering the appropriate two-digit place-of-service code. A place of service code is included.**
24C	EMG	EMG means emergency. Enter "Y" for yes or leave blank for no.
***24D**	**Procedures, Services or Supplies**	**Enter HCPCS Level I codes (CPT), Level II codes (A-DMEPOS) and modifiers. Enter the procedure code that best describes the service provided. If the CPT and A-DMEPOS code describe the same service, submit the CPT code. Use appropriate modifiers; up to four modifiers may be submitted. Miscellaneous CPT codes must include a description. Claims with missing or invalid procedure codes will be denied for correction and resubmission.**
***24E**	**Diagnosis Code**	**Enter diagnosis pointer(s) referenced in field 21 to indicate which diagnosis code(s) apply to the related HCPCS code. Do not enter ICD-10-CM codes or narrative descriptions in this field. Do not use slashes, dashes or commas between reference numbers.**
***24F**	**$ Charges**	**Enter the charge amount in (dollars|cents) format. If more than one date or unit is shown in field 24G, the dollar amount should reflect the TOTAL amount of the services. Do not indicate the balance due, patient liability, late charges/credits or a negative dollar line. Do not use decimals or dollar signs.**
***24G**	**Days or Units**	**Enter the number of days or units for each service billed. For anesthesia services, report time units and modifiers on a separate line.**

24H	EPST Family Planning	Leave blank.
24I	ID Qualifier	Enter “NPI.”
24J	Rendering Provider ID	Enter ID 10-digit NPI number.
***25**	**Federal Tax ID Number**	**Enter your employer identification number (EIN) and place an “X” in the EIN box. If not available, enter your Social Security number (SSN) and place an “X” in the SSN box. Only one box can be marked.**
26	Patient’s Account Number	Enter the patient’s account number.
***27**	**Accept Assignment**	**For patients with Medicare coverage, place an “X” in the appropriate box.**
***28**	**Total Charges**	**Enter the sum of the charges in column 24F (lines 1-6). Enter the total charge amount in (dollars|cents) format. Do not use negative numbers.**
29	Amount Paid	Enter the amount paid from the patient or other payer. An explanation of benefits (EOB) may be required.
30	Balance Due	Enter the difference between box 28 and box 29.
***31**	**Signature of Physician or Supplier Including Degrees or Credentials**	**Enter the signature of the physician, provider, supplier or representative with the degree, credentials or title and the date signed. Stamped and printed signatures are accepted.**
32	Service Facility Location Information	Enter the name and actual address of the organization or facility where services were rendered if other than box 33 or patient’s home. Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, ZIP code
32A	NPI	Enter the 10-digit NPI.

32B	Other ID	Enter the Medicare-assigned unique physician identification number (UPIN) of the physician listed in box 32.
***33**	**Billing Provider Info and Phone Number**	**Enter this information in the following format:** **Line 1: name of physician or clinic** **Line 2: address** **Line 3: city, state, ZIP code** **Phone number must be entered in the area to the right of the box title. The area code is entered in parentheses; do not use a hyphen or space as a separator.**
33A	**NPI**	**Enter the 10-digit NPI.**
33B	**Other ID**	**Enter the Medicare-assigned unique physician identification number (UPIN) of the physician listed in box 33.**

Appendix D - Place-of-Service Codes for Professional Claims

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

Place-of-Service Code(s)	Place-of-Service Name	Place-of-Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed or otherwise provided directly to patients (effective 10/1/05).
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location, owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services to tribal members who do not require hospitalization.

Place-of-Service Code(s)	Place-of-Service Name	Place-of-Service Description
08	Tribal 638 Provider-based Facility	A facility or location, owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/ Correctional Facility	A prison, jail, reformatory, work farm, detention center or any other similar facility maintained by either federal, state or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or intermediate care facility (ICF) where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some healthcare and other services (effective 10/1/03).
14	Group Home	A residence with shared living areas where clients receive supervision and other services such as social and/or behavioral services, custodial service and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place to place, equipped to provide preventive, screening, diagnostic and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, which is not identified by any other POS code (effective 4/1/08).

17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other place-of-service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment — Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides ongoing or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room — Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care, as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a hospital.

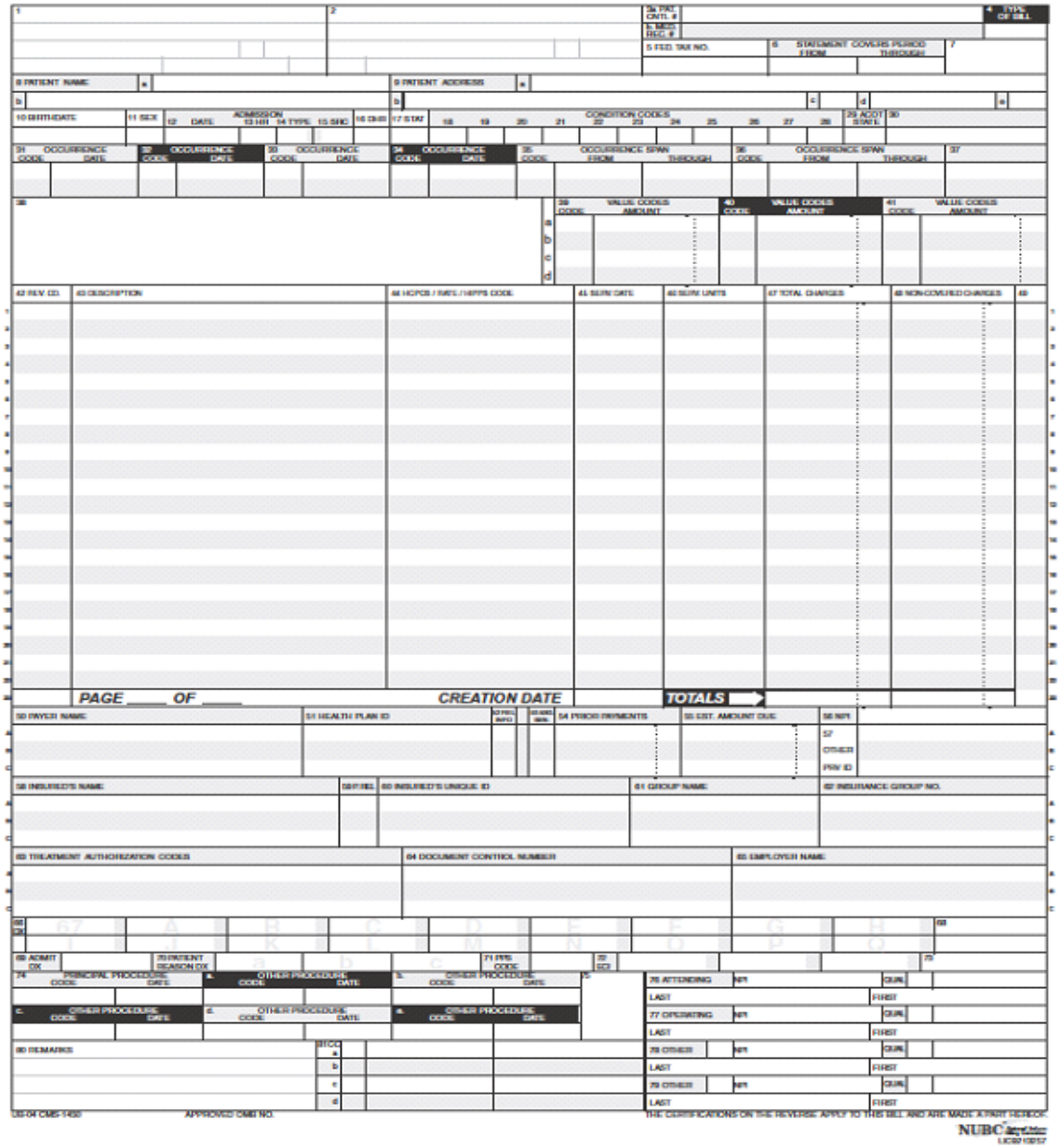
32	Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis, and that does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance — Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance — Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place-of-Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative or palliative services to outpatients only (effective 10/1/03).
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24-hour-a-day emergency care services; day treatment, other partial hospitalization services or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies and psychological testing (effective 10/1/03).
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital that provides dialysis treatment, maintenance and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician (effective 10/1/03).
72	Rural Health Clinic	A certified facility that is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

Appendix E - Instructions to Complete the UB-04 / CMS1450 Form

New UB-04 – CMS 1450 Form



The Office of Management and Budget (OMB) and the National Uniform Billing Committee (NUBC) have approved the UB-04 claim form, also known as the CMS-1450 form. The UB-04 claim form will accommodate the national provider identifier (NPI) and has incorporated other important changes. The UB-04 form will be used exclusively for institutional billing.

The UB-04 Claim Form and NPI

The new UB-04 claim form includes several fields that accommodate the use of your NPI. If you have obtained your NPI(s) and submitted them to us, you must report them on the new UB-04 claim form.

If you have any questions regarding the NPI, the application process or reporting your NPI to us, please contact your network coordinator.

UB-04 Data Field Requirements

Field Location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Situational	Situational
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Situational	Situational
8b	Patient Name	Required	Required
9	Patient Address	Required	Required
10	Patient Birth Date	Required	Required
11	Patient Sex	Required	Required

Field Location UB-04	Description	Inpatient	Outpatient
12	Admission Date	Required	N/A
13	Admission Hour	Required	Required
14	Type of Admission/Visit	Required	N/A
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required if Applicable	Required if Applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Code and Dates	Required if Applicable	Required if Applicable
35-36	Occurrence Span Codes and Dates	Required if Applicable	Required if Applicable
37	Future Use	N/A	N/A
38	Subscriber Name and Address	Required	Required
39-41	Value Codes and Amounts	Required if Applicable	Required if Applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
44	HCPCS/Rates	Required if Applicable	Required if Applicable
45	Service Date	N/A	Required
46	Units of Service	Required	Required
47	Total Charges (By Rev Code)	Required	Required
48	Non-Covered Charges	Required if Applicable	Required if Applicable

49	Future Use	N/A	N/A
50	Payer Identification (Name)	Required	Required
51	Health Plan Identification #	Situational	Situational
52	Release of Info Certification	Required	Required
53	Assignment of Benefit Certification	Required	Required
54	Prior Payments	Required if Applicable	Required if Applicable
55	Estimated Amount Due	Required	Required
56	NPI	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required
61	Insured Group Name	Situational	Situational
62	Insured Group Number	Situational	Situational
63	Treatment Authorization Codes	Required if Applicable	Required if Applicable
64	Document Control Number	Situational	Situational
65	Employer Name	Situational	Situational
66	Diagnosis/Procedure Code Qualifier	Required	Required
67	Principal Diagnosis Code/Other Diagnosis	Required	Required
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Required if Applicable
70	Patient's Reason for Visit	Situational	Situational

71	PPS Code	Situational	Situational
72	External Cause of Injury	Situational	Situational
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required if Applicable	Required if Applicable
75	Future Use	N/A	N/A
76	Attending Name/ID Qualifier 1G	Required	Required
77	Operating ID	Situational	Situational
78-79	Other ID	Situational	Situational
80	Remarks	Situational	Situational
81		Code-Code Field/Qualifiers	
*0-A0	N/A	N/A	
*A1-A4	Situational	Situational	
*A5-B0	N/A	N/A	
*B1-B2	Situational	Situational	
*B3	Required	Required	

Appendix F - Explanation of Payment

Explanation of payment

Patient: Julie Q. Jones

Claim #: 190774426101
Patient account: 1078300740
Subscriber: Jane Q. Smith
Subscriber ID: J54037757
Group ID: 10002805
Group: Sample Group
Provider ID: P00001110998
Provider: Sample Provider
Network: Connexus

Service date (from / to)	Type of service	Procedure code	Total charge	Non-covered charges	Deductible	Provider discount/ amount not covered	Provider withhold	Remaining covered charges	Copay/ coinsurance	Patient responsibility	Total benefit	Benefit paid to provider	Reason code(s)
0312 / 031219	Office visit	99214	$258.00	$0.00	$0.00	$3.86	$0.00	$254.14	$20.00	$20.00	$234.14	$0.00	PDC
0814 / 081419	Lab service	36415	$7.00	$0.00	$0.00	$3.10	$0.00	$3.90	$0.00	$0.00	$3.90	$0.00	PDC
Totals			$265.00	$0.00	$0.00	$6.96	$0.00	$258.04	$20.00	$20.00	$238.04	$238.04	A22

Previously paid to provider: **$0.00**
Additional benefit paid to provider: **$238.04**

Comments

<Comment one goes here>

Reason code	Description
PDC	Provider discount has been applied.
A22	Claim adjusted to reflect corrected benefits.

Total summary

Total charge	**$265.00**
Benefits paid	$238.04
Overpayment deductions	($64.20)
Total payment	**$173.84**
Remaining overpayment balance	**$0.00**

moda HEALTH

Date: 10/25/19
Payee ID: P00000901547
Payee: Legacy Emanuel Clinic

Appendix G - Billing Tips

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.
- Include all pertinent information — e.g. date of birth, subscriber ID*, and valid CPT and ICD-9 or ICD-10 codes, as applicable. *Please enter subscriber ID exactly as it appears on the Member ID card (this is not the member/patient's Social Security number).
- If the member is covered by more than one Moda Health program, submit one claim form indicating the name of the subscriber, subscriber ID, employer (if applicable) and Moda Health 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 a carrier other than Moda Health, the EOB from that insurance company must accompany the claim for consideration of payment if the claim is being filed on paper. If Moda Health is the secondary payer and the claim is being filed electronically, the payment information from the primary carrier should be sent electronically along with the electronic claim information.
- Moda Health makes weekly payments.
- Please contact Moda Health Customer Service or check Benefit Tracker before submitting duplicate claims:
  - Rebilling without contacting us slows our turnaround time and delays payment.
  - Check the 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 modahealth/medical or contact the Benefit Tracker Administrator by phone at 503-265-5616 or 877-277-7270, or by fax at 503-948-5577.
  - If you receive a PDR 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. This has the effect of blacking out the information that was highlighted when the claim is scanned by our systems.

Common reasons a claim might be denied, paid at a lower benefit, or returned for a corrected billing:

- Member is not eligible. A member's card is NOT a guarantee of eligibility. (See the Member Eligibility & Benefit Verification section in this manual.)
- Coverage is not yet in effect or has been terminated.
- 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-CM code
    - Full name and address of provider with the tax ID number
- No authorization on file for procedure.
- No PCP selected by member.
- Member was seen by specialist for routine services. The member's PCP must provide these services.
- Member was seen by PCP's on-call physician and claim did not indicate this. Please indicate by stating on top of claim "ON CALL." This will alert our processors that the physician utilized was on call for member's PCP.
- Member has other primary coverage, and EOB was not received with claim.
- Procedure or service is a noncovered service. Please contact Customer Service to verify if the procedure is a covered service or if there are any questions.

Appendix H - Records Needed for Specific Modifiers

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 Moda Health to request the needed records, and 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 actually completed as compared to the complete procedure. (See reimbursement policies RPM018, "Modifier 53 – Discontinued Procedure" and RPM049, "Modifiers 73 & 74 - Discontinued Procedures For Facilities.")

	Modifier description	Records needed
-58	Staged or related procedure	Preoperative history and physical and operative report for original and current surgeries (see reimbursement 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 that case, all medical records (including dictated and/or handwritten notes and any diagrams) documenting the visit and the surgical procedure code should be submitted when the operative report is requested.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