



Moda Health PPO Participating Provider Manual



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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 members, and our participating physicians and providers.

CONTACT LIST

We're only a call away

Our team of experts is available to help you with any questions you may have regarding health plans, patient eligibility or Moda Health programs. Our team is available to answer your calls Monday through Friday from 7:30 a.m. to 5:30 p.m Pacific Standard Time, excluding holidays.

Telephone numbers

Medical Customer Service

Email: medical@modahealth.com

Local: 503-243-3962

Toll-free: 877-605-3229

Pharmacy Customer Service

Email: pharmacy@modahealth.com

Local: 503-243-3962

Toll-free: 877-605-3229

Fax: 800-207-8235

Moda Health Behavioral Health

Email: behavioralhealth@modahealth.com

Toll free: 800-799-9391

Authorizations: 855-294-1665

Fax: 503-670-8349

Provider Credentialing

Email: credentialing@modahealth.com

Toll-free: 855-801-2993

Fax: 503-265-5707

Referrals/Authorizations Medical Intake

Local: 503-243-4496

Toll-free: 800-258-2037

Fax: 503-243-5105

Press 1 for Referral and Authorization Status

Press 2 for Medical Intake

Press 3 for Claims/benefits

Healthcare Services: Case Management and Disease Management

Local: 503-948-5561

Toll-free: 800-592-8283

Fax: 503-243-5105

Electronic Data Interchange

Email: edigroup@modahealth.com

Local: 503-243-4492

Toll-free: 800-852-5195

Fraud, Waste and Abuse

Email: stopfraud@modahealth.com

Toll-free: 855-801-2991

Benefit Tracker

Local: 503-265-5616

Toll-free: 877-277-7270

Email: ebt@modahealth.com

Provider Contract Renewals

Email: Contractrenewal@modahealth.com

PROVIDER RELATIONS AND CONTRACTING INFORMATION

Provider Configuration

Email: Providerupdates@modahealth.com

Fax: 503-243-3964

Provider Services Representative

Email: Providerrelations@modahealth.com

Fax: 503-243-3964

Contact Medical Provider Configuration for:

- New provider information
- Adding or deleting a provider
- Adding Provider NPI
- Updating provider phone number
- Updating provider address
- Updating provider TIN number (W-9 required)
- All other demographic updates

Contact Provider Services for:

- Escalated or trending claims issues
- Medical provider workshop information
- Provider education materials
- Reimbursement policy manual and Medical necessity criteria updates

New Provider Nominations

To initiate a new contract with Moda, Inc., visit www.modahealth.com/medical/contracting/overview

Medical Provider Contract Renewal

Email:

Contractrenewal@modahealth.com

Contact Contract Renewal for:

- Contract renegotiations

FREQUENTLY ASKED QUESTIONS

Whom do I contact for chemical dependency and behavioral health contracting?

Please visit www.modahealth.com/medical/contracting/overview for more information on becoming a preferred provider for chemical dependency and mental health services.

Do you contract with vision providers?

Yes, if you wish to be contracted directly with Moda Health, we welcome your participation.

Benefit plan designs vary from vision-only benefit plans, benefit plans that are simply a dollar amount, or benefit plans that require members to see an in-network vision provider. Please be sure to verify member vision exam and hardware benefits on our free, online provider resource Benefit Tracker.

What can I find on the Moda Health website?

The Moda Health website contains the following:

- A description of the Moda Health quality improvement program and a report on the organization's progress in meeting its quality improvement goals
- Information on the availability of the Case Management program and contact information for practitioner referral
- The Moda Health Disease Management program and how to use its services
- Research on proven safe clinical practice
- Clinical practice guidelines
- Moda Health policies and procedures for medical record criteria
- Utilization management criteria
- Pharmaceutical management procedures
- Moda Health policy to encourage appropriate utilization and discourage underutilization of services
- The Moda Health Reimbursement Policy Manual
- Members' rights and responsibilities, including the right to language assistance
- Tobacco cessation educational materials

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

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

How can providers review Moda Health medical necessity criteria?

Moda Health medical necessity criteria, along with a description of how they are developed, are available for your review at www.modahealth.com/medical/medical_criteria.shtml. You may also request a printed copy of specific criteria by calling Moda Health Medical Intake at 503-243-4496.

How can providers review Moda Health reimbursement policies?

Moda Health's reimbursement policy manual is available for your review at www.modahealth.com/medical/policies_reimburse.shtml. Individual policies may be printed in a PDF format. Please check back periodically for updates and additional topics.

MEDICAL PROVIDER CONTRACTING

What types of provider contracts does Moda Health offer?

Moda Health offers Commercial, Medicare contracts and Medicaid in certain counties. If you have questions about your current contract or to find out which networks you are participating in, please contact your Provider Relations Representative. If you are a new provider without an established relationship with Moda Health and you would like more information on how to become contracted please visit www.modahealth.com/medical/contracting/overview.

How do providers join the Moda Health panel?

To get the participation process started, please visit www.modahealth.com/medical/contracting/overview, fill out the short form, and tell us a little about yourself so we can get to know you and your practice better.

Contracting is contingent on credentialing approval through Moda, or by a delegated credentialing entity. You don't need to begin the credentialing process until your contracting request submission has been reviewed. To learn more about credentialing, please visit our [Credentialing page](#).

What are the steps involved in credentialing?

The first step is to submit a completed Oregon Practitioner Credentialing Application approved by the ACPCI, or a Washington Practitioner Credentialing Application if practicing in Washington. If you need a copy of the Oregon credentialing or recredentialing application, you can access an electronic copy from the Oregon Health Plan Policy and Research website at www.oregon.gov/oha/OHPR/ACPCI/pages/state_app.aspx.

- The Moda Health Credentialing staff will process the application by verifying the information and will contact your office if additional information is needed.
- Once the verification is complete, the credentialing supervisor, medical director and/or credentialing committee review the application for any concerns, and a decision for participation is made.
- A letter is sent to the provider within thirty days of the Credential Out-of-Network Service Authorization Requests Committee meeting to notify the provider of Moda Health's decision.

Does Moda Health offer electronic billing?

Yes, please contact the Moda Health Electronic Data Interchange (EDI) department at 503-243-4492 or by email at edigroup@modahealth.com.

How do I get a directory of Moda Health network providers?

You can access Moda Health's provider directory by visiting:

www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml.

Provider directories are also available upon request.

PLAN DESCRIPTIONS/PRODUCT SUMMARIES

Moda Health offers medical benefit plan options to employers and individuals. Employers choose from a wide variety of preferred provider organization (PPO) and point-of-service (POS) plans with an exceptional range of options. Individual plans and Medicare supplement coverage are also available.

Moda Health administers a variety of preferred provider organization (PPO) and point-of-service (POS) plans. For these plans the following panels are used, either alone or in combination. A complete listing of providers can be found online at www.modahealth.com/ProviderSearch/faces/webpages/home.xhtml.

OREGON

Connexus Network This is one of the largest PPO networks in Oregon. It includes thousands of primary care physicians and specialists working together with Moda Health to help our members stay healthy. Effective January 1, 2016, Connexus is available to employer group members only.

Synergy Network The Synergy network offers an integrated care experience to members living in select western Oregon and southwest Washington counties. This network connects members to a Moda Medical Home, who work together to coordinate care, and keep members feeling their best. Synergy offers a diverse and wide selection of participating providers, offering high-quality care, close to home.

Summit Network The Summit network offers an integrated care experience to members living in select Eastern Oregon counties. This network connects members to a Moda Medical Home, who work together to coordinate care, and keep members feeling their best. Summit offers a diverse and wide selection of participating providers, offering high-quality care, close to home.

Beacon EPO network The Beacon network is available to Individuals who purchase health coverage directly from Moda or through the federal marketplace exchange, and reside in **Clackamas, Clatsop, Columbia, Coos, Curry, Hood River, Jackson, Josephine, Marion, Multnomah, Polk, Yamhill, Tillamook, Washington or Wasco** counties. The Beacon network brings together nine health systems including **OHSU, Portland Adventist, Columbia Memorial Hospital, Bay Area Hospital, Mid-Columbia Medical Center, Asante, Salem Health, Tuality, Tillamook Regional Medical Center** and **Willamette Valley Medical Center**. Members can see in-network providers in the Oregon counties listed above.

Affinity EPO network Affinity network is available to Individuals who purchase health coverage directly from Moda or through the federal marketplace exchange, and reside in **Baker, Crook, Deschutes, Gilliam, Grant, Harney, Jefferson, Klamath, Lake, Lane, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler** counties. The Affinity network brings together 10 health systems including **Blue Mountain Hospital, Good Shepherd, Grande Ronde, Harney District Hospital, Lake District Hospital, Morrow County Health District, PeaceHealth, Pioneer Memorial Hospital, Sky Lakes Medical Center, St. Alphonsus Baker City, St. Alphonsus Ontario, St. Anthony Hospital, St. Charles Health System** and **Wallowa Memorial Hospital**.

Affinity members can see in-network providers in the Eastern Oregon counties listed above, and some areas in Washington and Idaho.

Cornerstone EPO (new Jan. 1, 2019) The Cornerstone network is a Legacy Health based network, available to Individuals who purchase health coverage directly from Moda or through the federal marketplace exchange, and reside in Multnomah, Clackamas, or Washington counties. Legacy Health serves as the foundation of the Cornerstone network. Numerous primary care and specialty providers and clinics who work with Legacy Health will be participating in the Cornerstone Network.

Please note: Beginning Jan. 1, 2019, all Oregon Individual plans including Beacon EPO, Affinity EPO, and Cornerstone EPO, will be connected to an Exclusive Provider Organization (EPO) network. Individual EPO plans do not have out-of-network benefits, so it is important that your patients are referred to providers within the Individual plan and network in which the patient is enrolled.

Please review your patient's Moda member ID card and check our provider directory Findcare, to ensure care is referred to other in-network Beacon, Affinity, or Cornerstone providers. Services provided to Moda Individual members by out-of-network providers will result in higher costs for patients enrolled in these plans.

Community Care Network (CCN) This network serves Portland and Salem communities. It includes a select group of Legacy Health, Salem Health, Adventist Health, PeaceHealth, St. Charles and OHSU providers that work together to give you the best care. Members have access in Multnomah, Washington, Clackamas, Yamhill, Marion and Polk counties.

WASHINGTON

First Choice Health Network, Inc. (FCHN)

FCHN is a company owned by hospitals and physicians throughout Washington. FCHN contracts with hospitals, clinics, physicians and other caregivers in Washington, Idaho and Montana. FCHN contracts with more than 49,000 physicians and other ancillary providers, and nearly 200 hospitals in this three-state region. A complete listing of providers can be found online through First Choice's website at www.fchn.com.

IDAHO

Idaho Physicians Network (IPN)

Connexus members can access care or service in Idaho through our partnership with IPN. IPN's service area includes 34 of the 44 counties throughout Idaho. IPN has extensive network coverage throughout the southwestern and southeastern parts of Idaho. A complete listing of providers can be online at www.ipnmd.com.

ALASKA

Pioneer network The Pioneer Network was developed to provide cost-effective, coordinated care for residents of the Kenai Peninsula Borough. Pioneer offers three benefit levels (tiers) of healthcare:

- **Tier One** - For Kenai Peninsula Borough residents seeking coordinated care in the community. See our Tier One providers available in your area.
- **Tier Two** - For members seeking care outside of the Kenai Peninsula Borough. This includes First Choice Network in Alaska and Alaska Regional Hospital.
- **Tier Three** - For all other providers not in Tier One or Tier Two.

Endeavor Providence Network This Alaska network covers participating physicians, clinics and ancillary providers throughout the state. It includes Providence Alaska Medical Center as the preferred provider of acute care services in the Anchorage area. Members also have access to the First Choice network. The Endeavor Providence Network includes over 1,100 physicians and nearly 20 hospitals. A complete listing of Endeavor Providence Network providers may be found at www.modahealth.com.

Endeavor Select Network This Alaska network covers participating physicians, clinics and ancillary providers throughout the state. It includes Alaska Regional Hospital as the preferred provider of acute care services in the Anchorage area. Members also have access to the First Choice PPO panel.

NATIONAL NETWORKS

MultiPlan/Private HealthCare Systems (PHCS) The PHCS Network is the largest proprietary PPO network in the country. With 700,000 providers and nearly 4,600 facilities in the network, members have access to a quality network of providers wherever they may be. As a proprietary network, PHCS contracts directly with every provider participating in the network. The PHCS network is available only to Moda Health members who live outside the Moda Health primary service areas. A complete listing of providers can be found in the PHCS PPO Network directory or the online provider search tool at www.multiplan.com.

TRAVEL NETWORK

First Health

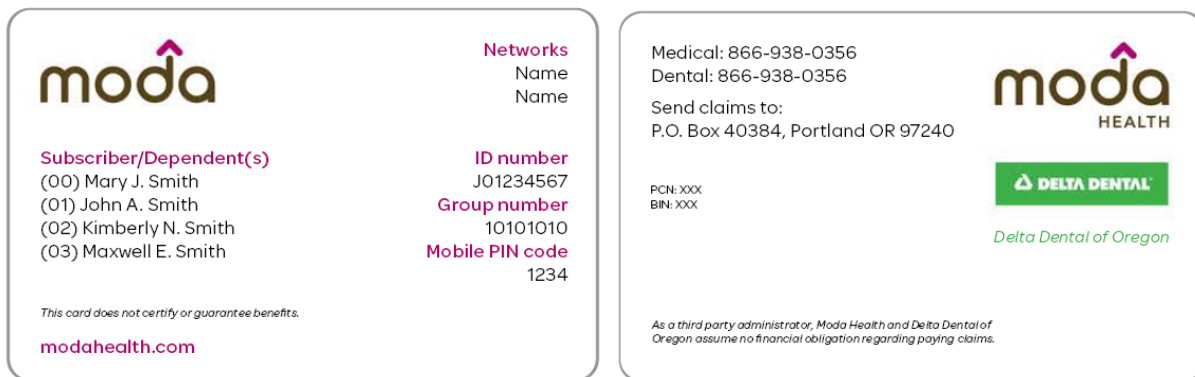
Our travel networks come with each medical plan in Oregon. Members traveling outside of their primary service area may receive the in-network benefit level by using a First Health provider. The in-network benefit level applies to a travel network provider only if members are outside the primary service area and the travel is not for the purpose of receiving treatment or benefits.

The following are examples of Moda Health Member Identification cards.

Network Information – A network is a group of providers who contract with Moda Health to provide services to our members

ID Number – Each subscriber has a unique number that identifies them. ID numbers can be a combination of letters and numbers.

Group Number – The group number is the unique number assigned to an employer. This number also identifies individual plan policy holders.



VERIFYING MEMBER ELIGIBILITY AND BENEFITS

There are four ways that you can verify member eligibility and benefits with Moda Health. It can be done electronically 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

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

OPTION 2: Contact us by 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 7:30 a.m. to 5:30 p.m. PST, excluding holidays.

OPTION 3: Call Customer Service at 888-217-2363

Armed with the very latest details on all policies and procedures, our customer service staff will always give you the best information available. You can reach them Monday through Friday from 7:30 a.m. to 5:30 p.m. PST, excluding 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.

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 benefit handbook
- Claim status information
 - View claims online before the provider disbursement register (PDR) arrives.
 - Printable EOB available as the claim is processed (The information displayed is the same as the member's EOB. PDRs are currently not available in Enterprise Benefit Tracker)
- Referrals (to find out how to access online referral, please visit our website to view a demonstration)
 - PCP offices are able to make referrals (new and retroactive back to 90 days) for their patients online.
- Current PCP information

Benefit Tracker is a HIPAA-compliant online service.

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

Getting started

To sign up online, visit www.modahealth.com/medical and follow the link on the right side of the page.

- Download an Electronic Services Agreement (ESA) from the website.
 - Have it signed by an authorized person from your office who can make agreements for the entire clinic (i.e. office manager or director of operations).
 - Return it to Moda Health via email to ebt@modahealth.com.
- Complete registration.
 - Have all Benefit Tracker users create their own user name and password online.

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

REFERRAL GUIDELINES

A very limited number of Moda plans require a referral. For specific referral requirements please contact customer service at the number found on the back of the members ID card.

If required referral requests may be submitted online using Benefit Tracker, phoned in to 503-243-4496 or toll-free to 800-258-2037, or faxed to 503-243-5105.

AUTHORIZATION GUIDELINES

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 Medical Providers, Authorization & 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 THAT REQUIRE PRIOR AUTHORIZATION

eviCore Healthcare

Advanced Imaging Utilization Management program

Beginning April 1, 2017 Moda will be replacing AIM Specialty Health with eviCore healthcare to assist with managing and administering benefits for advanced imaging and musculoskeletal services.

Applicable to all fully insured commercial, Medicare Advantage, and Medicaid lines of business, prior authorization requests for advanced imaging services must be performed by eviCore Healthcare for dates of service **beginning April 1, 2017**. eviCore will begin accepting prior authorization requests on March 27, 2017.

A complete list of advanced imaging services requiring prior authorization through eviCore can be found [here](#).

Musculoskeletal Utilization Management program

Moda has expanded its partnership with eviCore to include musculoskeletal utilization management programs which include Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy, Acupuncture, Spine Surgery, Chiropractic, Pain Management and Joint Surgery Management.

To verify your patient is employed by a group who requires prior authorization through eviCore for advanced imaging or musculoskeletal services, please check [Benefit Tracker](#) for specific member benefits.

Services performed without prior authorization will be denied to provider write-off and members may not be billed for these services.

For more information on eviCore healthcare's advanced imaging and musculoskeletal utilization management programs, or to place a prior authorization request through the eviCore healthcare provider portal, visit www.evicore.com, or call (844) 303-8451.

Services requiring prior authorization through Moda

For a list of services that require prior authorization through Moda Health, please visit www.modahealth.com/medical/referrals.shtml or call the Moda Health Medical Intake department at 503-243-4496 or toll-free at 800-258-2037.

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

Authorizations are subject to plan benefits and limitations. Even though a service is listed, coverage may be limited. Contact Customer Service 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 point-of-service (POS) 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 may be denied for lack of prior authorization or lack of medical necessity and the provider must hold the member harmless. The member may not be balance billed.

Note: Authorizations are not required when Moda Health is not the primary payer.

INVESTIGATIONAL SERVICES AND SUPPLIES

Services that are considered always not covered, always not medically necessary or always investigational will be denied as member responsibility.

INPATIENT SERVICES

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. Some plans may have a cost containment penalty that will apply if an inpatient stay does not have prior authorization. The specifics are listed in the member plan handbook under the cost containment section.

If a contracted provider fails to obtain prior authorization when required services may be denied for lack of prior authorization or lack of medical necessity.

Moda Health provides benefits for urgent/emergency hospital admissions.

NOTIFICATION REQUIREMENTS

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.

If a contracted facility fails notify Moda of admissions and discharges within the required time-frame, the admission may be denied for lack of notification or lack of medical necessity.

INPATIENT CONCURRENT REVIEW

Moda 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 lack of notification or lack of medical necessity.

Providers are responsible for claims denied due to non-compliance with Moda Health notification and utilization management procedures and may bill members only for the appropriate copayment and deductible. Providers may not bill members for claims denied for lack of medical necessity if the provider failed to obtain required prior authorization for the service or failed to comply with required utilization review for the service.

DENIALS

Moda Health members and providers are notified of preauthorization decisions by Healthcare Services on a timely basis. The specialist or requesting provider is notified verbally or via facsimile when the review and decision are complete. Prior authorization turnaround times differ by group or individual health plan, subject to specific state and federal requirements. Denial letters will include the principal reason for denial and a copy of the member's grievance and appeal process.

BEHAVIORAL HEALTH SERVICES

The goal of the Moda Health Behavioral Health (Moda BH) Utilization Management program is to ensure the highest quality and most appropriate care for our members. The program is driven by a concern for positive treatment outcomes and seeks to ensure efficient use of resources. Moda Health acknowledges the role outcome-informed treatment can play in maximizing treatment effectiveness. We encourage behavioral health providers to actively monitor the process and effectiveness of treatment through use of standardized outcome measures. Clinical guidelines, including “Using outcome measures in outpatient psychotherapy,” can be found at www.modahealth.com.

Verifying Benefits

Behavioral health benefits and authorization requirements for Moda Health members may vary by plan. Providers are responsible for contacting Moda Health to determine whether authorization is required before providing services to any Moda Health member, and for obtaining any required authorization prior to rendering services.

Providers may obtain benefit information and authorizations by contacting Moda Health at 800-799-9391. Benefit information is also available online via Benefit Tracker at www.modahealth.com.

Utilization Management Methods

Moda Health uses two primary methods:

- **Prior Authorization:** Virtually all plans require prior authorization for the following levels of care:
 - Inpatient treatment: mental health and chemical dependency
 - Residential treatment: mental health and chemical dependency
 - Partial Hospital Program: mental health and chemical dependency
 - Intensive Outpatient Program: mental health only (level 2.1 chemical dependency intensive outpatient treatment does not require prior authorization)
 - Applied behavior analysis

(For emergency admissions, or if authorization cannot be obtained prior to admission, provider should contact Moda Behavioral Health at 855-294-1665 within two business days.)

- **Periodic Review and Consultation:** Routine outpatient services (including Level 2.1 chemical dependency intensive outpatient treatment) do not require prior authorization but are subject to review for medical necessity. In these cases, Moda Behavioral Health

may contact the provider and request a treatment plan and/or other clinical information. A Moda Health care coordinator may consult periodically with the treating provider.

Prior Authorization Process: Inpatient, Residential, Day Treatment and Mental Health Intensive Outpatient Services

- For emergency inpatient admissions, or if authorization cannot be obtained prior to admission, the provider should contact Moda Behavioral Health at 855-294-1665 within two business days. Otherwise, the provider should contact Moda Behavioral Health at 855-294-1665 prior to admission for initial authorization.
- If initial authorization is approved, the care coordinator will authorize an appropriate number of initial days and request a subsequent phone call for concurrent review as needed.
- Information required: The provider should submit clinical data justifying the requested level of care. This includes:
 - Diagnosis, symptoms, and functional impairment
 - Relevant psychosocial and treatment history
 - Alcohol and other drug use history
 - Current medical status and relevant medical history
 - Current medications
 - Risk assessment
 - Treatment plan
 - Specific goals for stabilization
 - Plan for outpatient follow-up following discharge
- In many cases, authorization can be completed over the phone. If the Moda Behavioral Health care coordinator or medical director determine written records are needed, records should be sent to Moda Behavioral Health at fax number 503-670-8349.

Periodic Review and Consultation

Routine outpatient services do not require prior authorization. Moda Health may request a treatment plan and/or other clinical documentation supporting medical necessity based on a review of claims. Providers must comply with requests for clinical documentation in such cases. Moda Behavioral Health will review the information provided and either:

- Contact the provider by phone for additional information;
- Notify the provider that treatment as outlined appears medically necessary and request a new treatment plan only if treatment is to extend beyond the time frame anticipated in the original treatment plan;

- Approve services with no further review required, unless Moda Health makes a specific request in the future;
- Approve services for a limited time period, with request for additional written information or clarification by a given date;
- Approve continued services for two weeks, with a request for the provider to call for telephonic review before the end of the two weeks;
- Review clinical information with the medical consultant or medical director. Note: Only a licensed physician (medical consultant or medical director) can deny requests for lack of medical necessity.

Treatment Plans: A copy of the Behavioral Health treatment plan form can be obtained online at www.modahealth.com or by calling the behavioral health utilization review line at 855-294-1665. The treatment plan must include:

- Diagnoses
- Symptom severity, baseline and current
- Relevant psychosocial and treatment history (there is limited space on the treatment plan form for this — additional information will be requested only if needed in order to make a utilization management decision)
- Assessment of both substance abuse and mental health concerns
- Scope and duration of planned treatment interventions
- Measurable treatment goals
- Response to treatment, including measurable change in symptom presentation
- ASAM assessment for chemical dependency services
- Medical conditions affecting treatment

Phone Review: In some cases, Moda Health and the provider may agree that periodic phone review is appropriate in lieu of a written treatment plan.

Provider Responsibilities

Providers are expected to participate in the Moda Health utilization review program.

Providers must:

- Make requests for initial authorization when required by the member’s benefit plan.
- Make requests for additional days (beyond those initially authorized) prior to the last authorized day.
- Provide a treatment plan and/or other clinical information in a timely manner when requested by Moda Health.
- Clearly express the client’s diagnosis, symptoms, measurable treatment goals, and tools for measuring progress, progress made and indicators of treatment completion.

Providers are responsible for claims denied due to non-compliance with Moda Health utilization management procedures and may bill members only for the appropriate copayment and

deductible. Providers may not bill members for claims denied for lack of medical necessity if the provider failed to obtain required prior authorization for the service or failed to comply with required utilization review for the service.

MODA HEALTH PHARMACY SERVICES

Rx Pharmacy Benefit Management (PBM) services are flexible in design to accommodate the specific needs of our clients. We partner with our customers to customize plans and management strategies, ensuring our programs provide the highest value, distinguished by exceptional customer service. We provide benefits to individuals, members of commercial and state groups, and Medicaid and Medicare Part D programs.

We use evidence-based research to manage our programs to produce the highest quality of care and member satisfaction at the lowest possible net cost to the plan. We manage the programs locally and leverage the technology, resources and expertise of our national PBM partner (MedImpact) to result in the best overall program for members.

A number of tactics are utilized to ensure the integrity of our pharmacy program and the administration of plan benefits. The purpose of these practices is to ensure the intended benefits are received by our members as well as providing management oversight of cost control measures and patient safety protocols.

In addition to ongoing quality assurance and administrative improvements, we listen to the needs of our customers and respond by employing communication strategies and defining new programs to meet the needs of select populations.

Our clients and members benefit from enhanced quality assurance (QA), formulary management, utilization and patient safety protocols and practices. Moda Health Rx operates from three fundamental principles that serve as the foundation of our programs and clinical initiatives; member safety, medication effectiveness, and cost effective pharmacotherapy.

Providers are able to access information pertaining to Moda Health members through the Moda Health website and Electronic Benefit Tracker (EBT). As a reference, some of the information practitioners may find on the Moda Health website and EBT is listed below:

- A search tool for in-network pharmacies
- Forms to initiate review protocols on medications that require authorization (e.g. prior authorization, step therapy, quantity limitations)
www.modahealth.com/pdfs/rx_priorauth_form.pdf
- Prescription mail service order forms
www.modahealth.com/medical/rx_partners.shtml
- Individual and small group formulary and restrictions
(modahealth.com/plans/individual/pharmacy)
- Large groups — medications requiring authorization
www.modahealth.com/medical/rx_utilization_management.shtml
- Recent FDA drug safety and recall information
www.modahealth.com/medical/drugs.shtml

- Information available through EBT
- A provider may log onto EBT by going to www.modahealth.com/medical and clicking on the Electronic Benefit Tracker link.
- Member benefits and eligibility
- Preferred drug list
- Prior authorization drug list
- Specialty fulfillment list
- Value tier list
- Vaccine list

Specialty Drug Program

Moda Health Rx provides members prescribed specialty medications and access to enhanced clinical services through Ardon Health Pharmacy. Certain prescription drugs or medicines, including most self-injectables as well as other medications, must be purchased through an exclusive specialty pharmacy provider to be a covered benefit. This may include specialty tier and other tier medications. **If a member does not purchase these drugs from Ardon Health or another designated limited distribution drug pharmacy, the drug expense will not be covered.**

Each specialty prescription is typically limited to a 30-day supply per dispensed prescription and often requires prior authorization. Select specialty medications that have been determined to have a high discontinuation rate or short duration of use may be limited to a 15-day supply for up to the first 90 days of treatment.

Information about Moda Health Rx's specialty pharmacy is available by calling Ardon Health at 855-425-4085 or by visiting www.ardonhealth.com.

Biosimilar Pharmaceuticals

Biosimilar pharmaceuticals are closely matched successors to off-patent biologics and offer more cost-effective versions of their branded originators. An interchangeable biosimilar is a type of biological product that is licensed by the FDA because it is highly similar to an already FDA-approved biological product (reference product); has been shown to have no clinically meaningful difference from the reference product; and is expected to produce the same clinical result as the reference product in any given patient.

Moda Health Rx's goal is to provide members with a balanced pharmacy benefit that reflects our dedication to the health and safety of our members while ensuring the most effective distribution of therapeutic options at the best available cost. Because FDA-approved biosimilar agents deliver the same therapeutic result at a lower cost, Moda encourages the use of FDA-approved interchangeable biosimilar pharmaceutical products for its members.

Mail Order Pharmacy

Moda Health Rx members have the option of obtaining prescriptions for chronic use medications through an exclusive mail order pharmacy. Each mail order prescription is limited to a 90-day supply per prescription.

Moda Health Rx has partnered with Postal Prescription Services (NW Prescription Drug Consortium and Moda Health commercial plans) and Walgreens Mail-order (Moda Health commercial plans) to provide mail order pharmacy services to its members. Moda Health Rx's mail order pharmacy providers may be reached at:

Postal Prescription Services (PPS): 800-552-6694

Walgreens Mail-order: 866-525-1590

Choice 90 Pharmacies

Many Moda large group plans offer a 90 day retail supply for chronic medication use through Choice 90 pharmacies. To find a Choice 90 pharmacy, search Find Care at www.modahealth.com and check the box to filter to Choice 90 pharmacies. Network options available to members can be found within EBT.

Value Tier Medications

Moda Health Rx offers value tier medications at a reduced member cost share, typically ranging from a \$0 to \$4 copay per 30-day supply. Value medications include select commonly prescribed products used to treat chronic medical conditions and preserve health by preventing greater outcomes from occurring. This can include medications to treat asthma, heart, cholesterol, high blood pressure, diabetes, depression and osteoporosis. To view the listing of value tier medications and associated copay for your member, please log in to EBT. Not all Moda Health plans include value tier medications.

Prior Authorizations

Certain prescription drugs and/or quantities of prescription drugs may require authorization by Moda Health Rx. Prior authorization (PA) refers to the process by which members must obtain approval from Moda Health Rx prior to purchasing a specific drug. A complete list of drugs that require authorization is available online through EBT.

To initiate an authorization review with Moda Health Rx, please call Moda Pharmacy Customer Service, or complete and return the prior authorization form (www.modahealth.com/pdfs/rx_priorauth_form.pdf), including all applicable chart notes and lab values. Calling Moda Health Pharmacy Customer Service at 888-361-1610 to initiate the authorization may expedite the process, as it will allow Moda to provide you with the specific

questions applicable to the medication being requested. In all instances it is important to return all forms and questions fully answered, with all applicable chart notes and lab values.

To initiate authorizations call: 888-361-1610

Moda authorization fax line: 800-207-8235

New FDA-approved medications are subject to a 180-day review and may be subject to additional coverage requirements or limits established. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the 180-day review period prior to Moda Health's Pharmacy & Therapeutic Committee evaluation.

Brand Substitution (DAW Policy) Moda Health plans include coverage for both generic and brand medications. For most Moda plans, if a member requests, or the treating professional provider prescribes, a brand medication when a generic equivalent is available, the member will be responsible for the brand cost sharing plus the difference in cost between the generic and brand medication. As the prescriber, if you feel there is medical necessity for the brand name medication, a review may be initiated by calling Moda Customer Service.

NDC REQUIREMENT For claims payment consideration under the medical or prescription benefit, claims for medications must include the National Drug Code (NDC). Billing with the NDC helps facilitate a more accurate payment and better management of drug costs based on what is being dispensed. Prescribers are required to submit a prescription drug's 11-digit NDC when submitting medical claims for drugs dispensed in a practice setting.

SELF-ADMINISTERED MEDICATIONS All self-administered medications, as labeled by the FDA, are subject to the pharmacy prescription medication requirements outlined in the member handbook, available through EBT. Self-administered specialty medications are subject to the same requirements as other specialty medications.

Self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility.

VACCINE COVERAGE Most Moda plans offers members with a pharmacy benefit for select immunization services through participating pharmacies. Under this program, members will have \$0 copay at participating pharmacies for the following immunizations:

- Influenza — inhalation or injection
- Meningococcal
- Pneumococcal
- Hepatitis A and hepatitis B
- Tetanus/diphtheria/pertussis
- Shingles (herpes zoster)
- Human papillomavirus (HPV)

- Varicella
- Polio
- Measles, mumps and rubella

Moda Health refers to the Centers for Disease Control and Prevention (CDC) recommendations, based on The Advisory Committee on Immunization Practices (ACIP), to define our coverage policies for vaccines.

Common Exclusions

- **Cosmetic Procedures.** Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired body function, including hormone treatment, rhinoplasty, breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery following a mastectomy and complications of reconstructive surgeries if medically necessary and not specifically excluded.
- **Devices.** Including but not limited to therapeutic devices and appliances.
- **Experimental or Investigational Medications.** Including any medication used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions
- **Foreign Medication Claims.** Medications purchased from non-U.S. mail order or online pharmacies or U.S. mail order or online pharmacies acting as agents of non-U.S. pharmacies
- **Hair Growth Medications**
- **Immunization Agents for Travel**
- **Infertility.** All services and supplies for office visits, diagnosis and treatment of infertility, as well as the cause of infertility
- **Institutional Medications.** To be taken by or administered to a member in whole or in part while the member is a patient in a hospital, sanitarium, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
- **Medication Administration.** A charge for administration or injection of a medication, except for select immunizations at in-network pharmacies
- **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
- **Medications Not Approved by FDA.** Products not recognized or designated as FDA-approved medications
- **Non-Covered Condition.** A medication prescribed for purposes other than to treat a covered medical condition
- **Nutritional Supplements and Medical Foods**
- **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission

- **Over-the-Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative
- **Repackaged Medications**
- **Replacement Medications and/or Supplies**
- **Self-Administered Medications.** Including oral and self-injectable, when provided directly by a physician's office, facility or clinic instead of through the prescription medication or anticancer benefits
- **Services Provided or Ordered by a Relative.** For the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner
- **Sexual Dysfunctions of Organic Origin.** The plan does not cover services for sexual dysfunctions of organic origin, including impotence and decreased libido. This exclusion does not extend to sexual dysfunction diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- **Treatment Not Medically Necessary**
- **Vitamins and Minerals**
- **Weight Loss Medications**
- **Work Related Conditions**

Common exclusions are provided as references for typical exclusions applied and may not apply to all members or plans. For the member-specific exclusions, please review the member handbook available through EBT.

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 www.modahealth.com/medical/policies.shtml. Please review the policies posted and check back periodically for updates and additional topics.

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, coinsurance and copayments, and for services not covered.

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.

Acceptable claim forms

Please file all claims using the standard CMS (formerly HFCA) 1500 or UB04/CMS 1450 claim forms. For more information, 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 www.nubc.org.

Incomplete 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.

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

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, DRG guidelines, AHA Coding Clinic, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

ICD-9 or ICD-10 codes, as applicable, should be reported to the highest level of specificity available. Incomplete codes may result in denial or delay of claims.

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 with explanation code 85M (One or more diagnosis codes on this claim requires more digits to be complete. Please resubmit the claim with a more specific diagnosis.) Invalid and incomplete diagnosis codes denials apply to all claims (all providers and all settings).

Inappropriate Diagnosis Codes in the Primary Diagnosis Position

Certain diagnosis codes are not eligible to be reported in the principle 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 principle diagnosis on facility claims. This CMS list will also be applied to Commercial claims for 2017 dates of service. Inpatient facility claims billed with an invalid primary diagnosis code for the setting will deny with explanation code 992 (Primary diagnosis is invalid for this setting. Please resubmit with valid primary diagnosis).

To view Moda Health's Diagnosis Code Requirement reimbursement policies [RPM053](#) and [RPM054](#).

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.

Reporting Professional Component of Hospital-Based Physician Services

Consistent with CMS guidelines, hospitals are to bill only for the technical component of a charge or service on the UB claim, and may not include a professional component amount in the calculation of their billed charge amounts. Moda Health requires all facilities to bill the physician's professional services on a CMS-1500 form or its electronic equivalent. Services must be identified on the CMS-1500 claim with an HCPCS or CPT code and a date of service. An ICD-9/ICD-10 diagnosis code that relates to the service rendered must be on the claim. All-inclusive rate facilities have the option of billing the hospital-based physician services separately or combined billing. The only exceptions to this policy are all-inclusive-rate hospitals and critical-access hospitals (CAHs).

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)."

Timely Filing Guidelines

All eligible claims for covered services must be received in our office within 12 months after the date of service, or as indicated in your provider participation agreement. 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.

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 a payment disbursement register (PDR) is not received within 45 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.

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

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 should be clearly marked with a notation indicating “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.

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 www.modahealth.com/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. Providers with a pattern of chronically submitting multiple copies of claims may be contacted for corrective action.

Corrected Claims

A corrected claim needs to be submitted whenever procedural codes, modifiers, diagnosis, dates, units or other information is being changed, or when surgical codes are being added. This corrected claim should be clearly marked with a notation indicating “corrected claim.” 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.

Corrective Action Required

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

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. When the billing provider receives a letter or fax requesting information needed for a review, if the requested documents and information are not received by Moda Health within the required timeframe, the record is deemed not to exist, and the services not documented. If the documentation is incomplete or insufficient to support the services, then the service or item will be considered as not documented.

Any records, documentation or information not received in response to the original records request or discovered after the review is complete will be considered for possible reconsideration of the review within the timely claim submission timeline. Please ensure that your response to records requests is both prompt and complete.

When services (procedure codes) are not documented, the record does not support that the services were performed, so they are not billable. Therefore, services that are determined to be not documented are denied to provider responsibility, and the member should not be balance-billed for the items. A refund will be requested if necessary (e.g., claim already released, postpayment review).

Records Fees, Copying Fees, etc.

It is Moda Health policy not to provide separate payment of fees for the routine completion and mailing of claim forms, insurance billings or related medical records. Any costs associated with copying and providing needed records are considered a cost of doing business for the provider or facility submitting the claim; reimbursement is included in the reimbursement for the services listed on the claim. Most Moda Health policies exclude “separate charges for the completion of records of claim forms and the cost of records.” See reimbursement policy #RPM005, “Records Fees, Copying Fees.”

Records Considered for Review

When submitting claims to the carrier, procedure codes are to be selected based upon the services documented in the patient’s medical record at the time of code selection.

- Legally amended corrections to the medical record made within 30 days of the date of service (outpatient) or date of discharge (inpatient) and prior to claims submission and/or selection for claim review will be considered in determining the validity of services billed.
- Any changes that appear in the record more than 30 days after the date of service/date of discharge or after a records request or payment determination will not be considered. In those cases, only the original record will be reviewed in determining payment of services billed to Moda Health.

Note: this policy is based on The Joint Commission’s timeliness standards and Noridian Medicare’s “Documentation Guidelines — Amended Records.” See Reimbursement Policy [RPM039](#), “Medical Records Documentation Standards.”

Legibility of Records

All records must be legible for purposes of review. Please use care to ensure that records are not rendered illegible by poor handwriting or poor copy quality. If the records cannot be read after review by three different persons within Moda Health, the documentation (or any unreadable portion) is considered illegible. When illegible records are received, the services are considered not documented and therefore nonbillable. 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.

A **late entry** supplies additional information that was omitted from the original entry. The late entry bears the current date and signature of the person adding the late entry, is added as soon as possible, and is written only if the person documenting has total recall of the omitted information.

Example: A late entry following treatment of multiple trauma might add: *“12/17/2009, late entry for 12/14/2009 — The left foot was noted to be abraded laterally.”*

An **addendum** is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record.

Example: An addendum for a 1/8/2010 visit could note: *“1/13/2010 Addendum: Past records arrived from previous PCP and were reviewed. The chest X-ray report was reviewed and showed that an enlarged cardiac silhouette was present in October 2009.”*

When making a **correction** to the medical record, never write over or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time and reason for the change. When a hard copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change and the identity of the person making that entry. 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.

Billing Tips

Here are some helpful hints to reduce claims processing time:

- Submit claims electronically.
- Before submitting a claim, verify that the plan information is correct and that the member's relationship to the subscriber is correct.
- 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 <http://www.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.

Here are some 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-9 or ICD-10 code, as applicable
 - 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.

Multiple Procedure Reductions

See Reimbursement Policy [RPM022](#), “Modifier 51 — Multiple Procedure Fee Reductions.”

Moda Health applies multiple procedure reductions to procedure codes with a CMS multiple procedure indicator of “1,” “2,” “3,” “4,” “5,” “6,” and “7.”

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

All procedure codes, including bilateral procedures, performed in one operative session must be submitted together. Splitting the codes on separate claims (fragmenting) may lead to incorrect payment of services.

Surgical codes are subject to multiple procedure cutbacks, unless they are designated as either exempt from modifier 51 or as “add-on” codes, Moda Health considers the primary procedure at 100 percent of allowance, and the remaining codes at 50 percent of allowance.

Regardless of the order in which the procedures are listed on the claim, the surgical code with the highest allowable fee (before the bilateral procedure adjustment) will be considered the primary procedure (processed at 100 percent) for the purpose of calculating multiple procedure adjustments. This ensures the best possible total reimbursement is issued for the allowed surgical codes.

Surgical codes that are designated as “add-on” codes are not eligible to be billed without the primary surgical code that they are added onto (base code). Add-on codes will be considered at 100 percent of allowance.

Surgical codes that are designated as modifier 51-exempt will be considered at 100 percent of allowance (multiple procedure indicator of “0” or “9”).

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

Moda Health applies the following multiple procedure reduction rules:

- a. Multiple radiology procedure reductions (indicator of “4”).
- b. Multiple therapy services reductions (indicator of “5”).
- c. Multiple diagnostic cardiovascular services reductions (indicator of “6”).
- d. Multiple diagnostic ophthalmology services reductions (indicator of “7”).

For details of these 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. Please see the information about our clinical editing policy listed in this manual.

Bilateral Procedures

See reimbursement policy [RPM057](#), “Modifier 50 – Bilateral Procedure.”

Bilateral procedures performed at the same operative session are reported by adding modifier 50 to the appropriate five-digit procedure code. The CPT editorial panel originally intended modifier 50 to be used as a one-line entry with units = 1 to report all of the work done on both sides.

However, they do permit the use of the two-line entry for bilateral services when the carrier requests or prefers the two-line entry method. The CPT Assistant instructs billing offices to “check with your local third-party payers to determine what is their preferred way for you to report bilateral procedures” (CPT Assistant, Spring 1992, page 19).

Moda Health specifically prefers and requests that all bilateral services be reported as a one-line entry using modifier 50 and units = 1. We have identified that claims with bilateral services submitted as a two-line entry (e.g. 31254, units = 1, and 31254-50, units = 1) are not always pricing correctly. If problems occur, a corrected claim using a one-line entry will be needed.

Not all procedure codes are eligible to be billed with modifier 50. The Medicare physician fee schedule database (MPFSDB) published by CMS contains a variety of indicators for each CPT and HCPCS code. The bilateral indicator identifies which procedure codes are eligible for bilateral reimbursement with modifier 50. Modifier 50 should only be added to procedure codes with a bilateral indicator of "1." If modifier 50 is submitted attached to procedure codes with a bilateral indicator of 0, 2, or 9, our system will recognize an inappropriate combination and generate denial code for invalid procedure to modifier combination. A corrected claim will be needed.

MPFSDB bilateral indicators:

- 0** Bilateral surgery rules do not apply. Do not use 50 modifier.
- 1** Bilateral surgery rules do apply. If performed bilaterally, use modifier 50, units = 1. Bilateral payment adjustment of 150 percent applies.
- 2** Bilateral surgery rules do not apply. Already priced as bilateral. Do not use 50 modifier. Units = 1.

- 3 The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests. Report bilateral services without modifier 50 (preferred), or with modifier 50 and units = 1.
- 9 Bilateral surgery concept does not apply.

If bilateral procedures are reported with other procedure codes on the same day, multiple surgery procedure adjustments apply as usual, in addition to the bilateral payment adjustment. Other payment adjustments (e.g. assistant surgeon, related procedure within postoperative period) also apply in addition, when appropriate.

Bilateral procedures performed on only one anatomical side

Procedures performed on only one anatomical side should not be billed with modifier 50. Modifiers LT and RT are programmed as valid only for procedures on body parts that exist only twice in the body, once on the left and once on the right (paired body parts). If the procedure code can only be performed in a single possible location on each side of the body, then modifier RT or LT may be used to indicate on which side the procedure was performed. However, if the procedure code can be performed on more than one possible location on each side of the body, modifier RT or LT should not be used in combination with that procedure code. Our system will recognize an inappropriate combination and generate a denial code for invalid procedure to modifier combination.

In these cases, modifier 59 may be the most appropriate choice to indicate that the procedure has been performed in a separate and distinct location, organ or incision. A corrected claim will be needed.

Reduced or Discontinued Procedures

See reimbursement policies [RPM003](#), “Modifier 52 — Reduced Services,” [RPM018](#) “Modifier 53 — Discontinued Procedure,” and [RPM049](#), “Modifiers 73 & 74 - Discontinued Procedures For Facilities.”

When modifiers 52 Reduced Services or 53 Discontinued Procedure are submitted on a line item, Moda Health reviews these claims against records on a case-by-case basis and adjusts the allowances based on the percentage of the full service that had been performed or documented.

A letter or brief statement should be attached to the claim or included with the records indicating what was different about the reduced procedure, or at what point the procedure was discontinued and why. It would be extremely helpful if this statement included an estimate of the percentage of work actually performed as compared to the work usually required or performed for the procedure code. For example, if a CT scan is billed with modifier 52, a notation that “Only 7 slices done; 15 are usually taken” clearly indicates the nature and amount

of the reduction. This information should be attached to paper claims. For electronic claims, please be prepared to supply this information for review.

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

Co-surgery Reimbursement

See reimbursement policy [RPM035](#), “Modifiers 62 & 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons).”

Modifier 62 indicates that two surgeons worked together as primary surgeons (co-surgeons), each performing distinct part(s) of a procedure. Modifier 62 must be added to the shared procedure code(s) on the claim from both co-surgeons. If modifier 62 is attached to the procedure code(s) on one surgeon’s claim, but is not present on the other surgeon’s claim, the claims cannot be adjudicated correctly. The second claim processed will be denied and a corrected claim or claims will need to be submitted so that both surgeon’s claims are in agreement. If an overpayment occurred on the first claim processed, a refund will be needed from the surgeon who did not add modifier 62 to the shared procedure codes.

If multiple procedures are performed in a single operative session, some procedures can be shared as co-surgeons and billed with modifier 62, and other procedures may be performed as usual with one surgeon acting as primary and the other as assistant. Modifier 62 should only be added to the shared procedures.

Co-surgery fee adjustment rates:

- Moda Health allows 60 percent of the usual contracted fee when modifier 62 is attached.
- Moda Health always splits co-surgery adjustments evenly as 60/60. Moda Health does not split co-surgery fees in any other ratios, even when requested by both co-surgeons involved.

Other fee adjustments apply in addition to the co-surgery fee adjustment, as appropriate (e. g. bilateral, related surgery during postoperative period, etc.). Multiple surgery procedure adjustments also apply. Regardless of whether part or all of the procedure codes are billed with modifier 62 for co-surgery, only one procedure code is eligible to be processed at 100 percent (primary) under the multiple surgery fee adjustment rule.

MODIFIERS FOR SURGICAL CODES

When surgical CPT codes are billed with certain modifiers, records will be needed to correctly process the claim. Please refer to the list below and attach the needed records to the claim when the claim is submitted. This will avoid unnecessary delays in processing for 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.”)
-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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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.

INSTRUCTION TO COMPLETE CMS 1500 FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA <input type="checkbox"/> FECA									
1. MEDICARE <input type="checkbox"/> (Member/ID#) MEDICAID <input type="checkbox"/> (ID#) TRICARE <input type="checkbox"/> (ID#/CoID#) CHAMPVA <input type="checkbox"/> (Member/ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA SUX/LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S ID NUMBER (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY		STATE		CITY		STATE		CITY	
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)		CITY	
8. RESERVED FOR NUCC USE				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:			
9a. OTHER INSURED'S POLICY OR GROUP NUMBER				9b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		10a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
9c. RESERVED FOR NUCC USE				9d. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		10b. OTHER CLAIM IS (Designated by NUCC)			
9e. RESERVED FOR NUCC USE				9f. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		10c. INSURANCE PLAN NAME OR PROGRAM NAME			
9g. RESERVED FOR NUCC USE				10d. CLAIM CODES (Designated by NUCC)		10e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to the party who accepts assignment below.)					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)				
SIGNED _____					SIGNED _____				
DATE _____					DATE _____				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
17b. NPI _____				17c. _____		19. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to service line below (21E) ICD In4									
A. _____		B. _____		C. _____		D. _____		E. _____	
F. _____		G. _____		H. _____		I. _____		J. _____	
K. _____		L. _____		M. _____		N. _____		O. _____	
P. _____		Q. _____		R. _____		S. _____		T. _____	
U. _____		V. _____		W. _____		X. _____		Y. _____	
Z. _____		AA. _____		AB. _____		AC. _____		AD. _____	
AE. _____		AF. _____		AG. _____		AH. _____		AI. _____	
AJ. _____		AK. _____		AL. _____		AM. _____		AN. _____	
AO. _____		AP. _____		AQ. _____		AR. _____		AS. _____	
AT. _____		AU. _____		AV. _____		AW. _____		AX. _____	
AY. _____		AZ. _____		BA. _____		BB. _____		BC. _____	
BD. _____		BE. _____		BF. _____		BG. _____		BH. _____	
BI. _____		BJ. _____		BK. _____		BL. _____		BM. _____	
BN. _____		BO. _____		BP. _____		BQ. _____		BR. _____	
BS. _____		BT. _____		BU. _____		BV. _____		BW. _____	
BX. _____		BY. _____		BZ. _____		CA. _____		CB. _____	
CC. _____		CD. _____		CE. _____		CF. _____		CG. _____	
CH. _____		CI. _____		CJ. _____		CK. _____		CL. _____	
CM. _____		CN. _____		CO. _____		CP. _____		CQ. _____	
CR. _____		CS. _____		CT. _____		CU. _____		CV. _____	
CW. _____		CX. _____		CY. _____		CZ. _____		DA. _____	
DB. _____		DC. _____		DD. _____		DE. _____		DF. _____	
DG. _____		DH. _____		DI. _____		DJ. _____		DK. _____	
DL. _____		DM. _____		DN. _____		DO. _____		DP. _____	
DQ. _____		DR. _____		DS. _____		DT. _____		DU. _____	
DV. _____		DW. _____		DX. _____		DY. _____		DZ. _____	
EA. _____		EB. _____		EC. _____		ED. _____		EE. _____	
EF. _____		EG. _____		EH. _____		EI. _____		EJ. _____	
EK. _____		EL. _____		EM. _____		EN. _____		EO. _____	
EP. _____		EQ. _____		ER. _____		ES. _____		ET. _____	
EU. _____		EV. _____		EW. _____		EX. _____		EY. _____	
EZ. _____		FA. _____		FB. _____		FC. _____		FD. _____	
FE. _____		FF. _____		FG. _____		FH. _____		FI. _____	
FJ. _____		FK. _____		FL. _____		FM. _____		FN. _____	
FO. _____		FP. _____		FQ. _____		FR. _____		FS. _____	
FT. _____		FU. _____		FV. _____		FW. _____		FX. _____	
FY. _____		FZ. _____		GA. _____		GB. _____		GC. _____	
GD. _____		GE. _____		GF. _____		GG. _____		GH. _____	
GI. _____		GJ. _____		GK. _____		GL. _____		GM. _____	
GN. _____		GO. _____		GP. _____		GQ. _____		GR. _____	
GS. _____		GT. _____		GU. _____		GV. _____		GW. _____	
GX. _____		GY. _____		GZ. _____		HA. _____		HB. _____	
HC. _____		HD. _____		HE. _____		HF. _____		HG. _____	
HH. _____		HI. _____		HJ. _____		HK. _____		HL. _____	
HM. _____		HN. _____		HO. _____		HP. _____		HQ. _____	
HR. _____		HS. _____		HT. _____		HU. _____		HV. _____	
HW. _____		HX. _____		HY. _____		HZ. _____		IA. _____	
IB. _____		IC. _____		ID. _____		IE. _____		IF. _____	
IG. _____		IH. _____		II. _____		IJ. _____		IK. _____	
IL. _____		IM. _____		IN. _____		IO. _____		IP. _____	
IQ. _____		IR. _____		IS. _____		IT. _____		IU. _____	
IV. _____		IW. _____		IX. _____		IY. _____		IZ. _____	
JA. _____		JB. _____		JC. _____		JD. _____		JE. _____	
JF. _____		JG. _____		JH. _____		JI. _____		JJ. _____	
JK. _____		JL. _____		JM. _____		JN. _____		JO. _____	
JP. _____		JQ. _____		JR. _____		JS. _____		JT. _____	
JU. _____		JV. _____		JW. _____		JX. _____		JY. _____	
JZ. _____		KA. _____		KB. _____		KC. _____		KD. _____	
KE. _____		KF. _____		KG. _____		KH. _____		KI. _____	
KJ. _____		KK. _____		KL. _____		KM. _____		KN. _____	
KO. _____		KP. _____		KQ. _____		KR. _____		KS. _____	
KT. _____		KU. _____		KV. _____		KW. _____		KX. _____	
KY. _____		KZ. _____		LA. _____		LB. _____		LC. _____	
LD. _____		LE. _____		LF. _____		LG. _____		LH. _____	
LI. _____		LJ. _____		LK. _____		LM. _____		LN. _____	
LO. _____		LP. _____		LQ. _____		LR. _____		LS. _____	
LT. _____		LU. _____		LV. _____		LW. _____		LX. _____	
LY. _____		LZ. _____		MA. _____		MB. _____		MC. _____	
MD. _____		ME. _____		MF. _____		MG. _____		MH. _____	
MI. _____		MJ. _____		MK. _____		ML. _____		MN. _____	
MO. _____		MP. _____		MQ. _____		MR. _____		MS. _____	
MT. _____		MU. _____		MV. _____		MW. _____		MX. _____	
MY. _____		MZ. _____		NA. _____		NB. _____		NC. _____	
ND. _____		NE. _____		NF. _____		NG. _____		NH. _____	
NI. _____		NJ. _____		NK. _____		NL. _____		NO. _____	
NP. _____		NQ. _____		NR. _____		NS. _____		NT. _____	
NU. _____		NV. _____		NW. _____		NX. _____		NY. _____	
NZ. _____		OA. _____		OB. _____		OC. _____		OD. _____	
OE. _____		OF. _____		OG. _____		OH. _____		OI. _____	
OJ. _____		OK. _____		OL. _____		OM. _____		ON. _____	
OO. _____		OP. _____		OQ. _____		OR. _____		OS. _____	
OT. _____		OU. _____		OV. _____		OW. _____		OX. _____	
OY. _____		OZ. _____		PA. _____		PB. _____		PC. _____	
PD. _____		PE. _____		PF. _____		PG. _____		PH. _____	
PI. _____		PJ. _____		PK. _____		PL. _____		PM. _____	
PN. _____		PO. _____		PP. _____		PQ. _____		PR. _____	
PS. _____		PT. _____		PU. _____		PV. _____		PW. _____	
PX. _____		PY. _____		PZ. _____		QA. _____		QB. _____	
QC. _____		QD. _____		QE. _____		QF. _____		QG. _____	
QH. _____		QI. _____		QJ. _____		QK. _____		QL. _____	
QM. _____		QN. _____		QO. _____		QP. _____		QQ. _____	
QR. _____		QS. _____		QT. _____		QU. _____		QV. _____	
QW. _____		QX. _____		QY. _____		QZ. _____		RA. _____	
RB. _____		RC. _____		RD. _____		RE. _____		RF. _____	
RG. _____		RH. _____		RI. _____		RJ. _____		RK. _____	
RL. _____		RM. _____		RN. _____		RO. _____		RP. _____	
RQ. _____		RS. _____		RT. _____		RU. _____		RV. _____	
RW. _____		RX. _____		RY. _____		RZ. _____		SA. _____	
SB. _____		SC. _____		SD. _____		SE. _____		SF. _____	
SG. _____		SH. _____		SI. _____		SJ. _____		SK. _____	
SL. _____		SM. _____		SN. _____		SO. _____		SP. _____	
SQ. _____		SR. _____		SS. _____		ST. _____		SU. _____	
SV. _____		SW. _____		SX. _____		SY. _____		SZ. _____	
TA. _____		TB. _____		TC. _____		TD. _____		TE. _____	
TF. _____		TG. _____		TH. _____		TI. _____		TJ. _____	
TK. _____		TL. _____		TM. _____		TN. _____		TO. _____	
TP. _____		TQ. _____		TR. _____		TS. _____		TT. _____	
TU. _____		TV. _____		TW. _____		TX. _____		TY. _____	
TZ. _____		UA. _____		UB. _____		UC. _____		UD. _____	
UE. _____		UF. _____		UG. _____		UH. _____		UI. _____	
UJ. _____		UK. _____		UL. _____		UM. _____		UN. _____	
UO. _____		UP. _____		UQ. _____		UR. _____		US. _____	
UT. _____		UU. _____		UV. _____		UW. _____		UX. _____	
UY. _____		UZ. _____		VA. _____		VB. _____		VC. _____	
VD. _____		VE. _____		VF. _____		VG. _____		VH. _____	
VI. _____		VJ. _____		VK. _____		VL. _____		VM. _____	
VN. _____		VO. _____		VP. _____		VQ. _____		VR. _____	
VS. _____		VT. _____		VU. _____		VV. _____		VW. _____	
VX. _____		VY. _____		VZ. _____		WA. _____		WB. _____	
WC. _____		WD. _____		WE. _____		WF. _____		WG. _____	
WH. _____		WI. _____		WJ. _____		WK. _____		WL. _____	
WM. _____		WN. _____		WO. _____		WP. _____		WQ. _____	
WR. _____		WS. _____		WT. _____		WU. _____		WV. _____	
WV. _____		WY. _____		WZ. _____		XA. _____		XB. _____	
XC. _____		XD. _____		XE. _____		XF. _____		XG. _____	
XH. _____		XI. _____		XJ. _____		XK. _____		XL. _____	
XM. _____		XN. _____		XO. _____		XP. _____		XQ. _____	
XR. _____		XS. _____		XT. _____		XU. _____		XV. _____	
XW. _____		XY. _____		XZ. _____		YA. _____		YB. _____	
YC. _____		YD. _____		YE. _____		YF. _____		YG. _____	
YH. _____		YI. _____		YJ. _____		YK. _____		YL. _____	
YM. _____		YN. _____		YO. _____		YP. _____		YQ. _____	
YR. _____		YS. _____		YT. _____		YU. _____		YV. _____	
YW. _____		YZ. _____		ZA. _____		ZB. _____		ZC. _____	
ZD. _____		ZE. _____		ZF. _____		ZG. _____		ZH. _____	
ZI. _____		ZJ. _____		ZK. _____		ZL. _____		ZM. _____	
ZN. _____		ZO. _____		ZP. _____		ZQ. _____		ZR. _____	
ZS. _____		ZT. _____		ZU. _____		ZV. _____		ZW. _____	
ZX. _____		ZY. _____		ZZ. _____					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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 an “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. <i>Note for Worker’s Compensation — use address of employer.</i>
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). <i>Enter the employee’s group health insurance information for Worker’s Compensation.</i>
9A	Other Insured’s Policy or Group Number	Enter the policy or group number of the other insured as indicated.
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: a. Employment (current or previous)? b. Auto Accident? c. Other Accident?	Only one box can be marked per category, per submission. a. Place an "X" in the appropriate box. If "yes," complete field 14. b. Place an "X" in the appropriate box. If "yes," indicate state and complete field 14. c. 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

		<p>qualifiers as appropriate to identify the role that this physician (or nonphysician practitioner) is performing:</p> <table> <tr> <td><u>Qualifier</u></td> <td><u>Provider Role</u></td> </tr> <tr> <td>DN</td> <td>Referring provider</td> </tr> <tr> <td>DK</td> <td>Ordering provider</td> </tr> <tr> <td>DQ</td> <td>Supervising provider</td> </tr> </table>	<u>Qualifier</u>	<u>Provider Role</u>	DN	Referring provider	DK	Ordering provider	DQ	Supervising provider
<u>Qualifier</u>	<u>Provider Role</u>									
DN	Referring provider									
DK	Ordering provider									
DQ	Supervising provider									

Field #	Field Name	Instructions — * = Required (also indicated in bold type) — All other required as applicable
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-9-CM diagnosis codes. List in order of relevance. Use the highest level of specificity. Do not provide 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-9-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	<p>Enter this information in the following format:</p> <p>Line 1: name of physician or clinic</p> <p>Line 2: address</p> <p>Line 3: city, state, ZIP code</p> <p>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.</p>
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.

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.
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	Birth 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.

NEW UB-04 — CMS 1450 FORM INSTRUCTIONS

New UB-04 – CMS 1450 Form

1		2		36 PRI CONT. #		4 TYPE OF BILL	
37 PAT. CONT. #		38 MED. REC. #		5 FEE/ TAX NO.		6 STATEMENT COVERS PERIOD FROM	
8 PATIENT NAME		9 PATIENT ADDRESS		7			
10 BIRTH DATE		11 SEX		12 DATE		13 ADMISSION	
14 HRT		15 SEC		16 DHR		17 STAT	
18		19		20		21	
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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
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

PAYMENT DISBURSEMENT REGISTER

PAYER:		PAYEE ID:											CHECK #:	
Model Office		PAYMENT DISBURSEMENT REGISTER											DATE:	
FOR SERVICES FROM TO	TYPE OF SERVICE	PROC CODE	TOTAL CHARGES	NON COVERED CHARGES	DEDUCTIBLE	PROVIDER DISCOUNT/DISALLOW	PROVIDER WITHHOLD	REMAINING COVERED CHARGES	CO-PAY	PATIENT RESPONSIBILITY	TOTAL BENEFIT	BENEFIT PAID TO PROVIDER	COMMENTS	
PATIENT: PATIENT CLAIM:		SUBSCRIBER: SUBSCRIBER ID:			GROUP ID: GROUP:			PROVIDER ID: PROVIDER NETWORK:						
0304	030415	Lab Service	81001	34.00	0.00	12.11	21.89	0.00	0.00	0.00	12.11	0.00	0.00 PPC	
TOTALS				251.00	0.00	193.65	57.35	0.00	0.00	0.00	193.65	0.00	0.00	
PATIENT: PATIENT ACCT: CLAIM:		SUBSCRIBER: SUBSCRIBER ID:			GROUP ID: GROUP:			PROVIDER ID: PROVIDER NETWORK:						
0311	031115	Lab Service	84270	48.00	0.00	48.00	0.00	0.00	0.00	0.00	48.00	35.12	35.12	
0311	031115	Lab Service	60103	76.00	0.00	70.33	5.67	0.00	0.00	0.00	70.33	0.00	0.00 PPC	
0311	031115	Lab Service	84443	66.00	0.00	64.26	1.74	0.00	0.00	0.00	64.26	0.00	0.00 PPC	
0311	031115	Lab Service	84403	57.00	0.00	57.00	0.00	0.00	0.00	0.00	57.00	41.72	41.72	
0311	031115	Lab Service	80053	42.00	0.00	40.38	1.62	0.00	0.00	0.00	40.38	0.00	0.00 PPC	
0311	031115	Lab Service	85025	30.00	0.00	29.73	0.27	0.00	0.00	0.00	29.73	0.00	0.00 PPC	
TOTALS				319.00	0.00	309.70	9.30	0.00	0.00	0.00	309.70	76.84	76.84	

COMMENTS:
 * Payment has been calculated based on contracted rate
 PPC Exceeds the Ambulatory Payment Classification (APC) rate.
 ST The patient is not eligible.
 A18 Claim adjusted; eligibility has been terminated since this claim was paid.
 L60 Individual out of pocket maximum has been met.
 A21 Claim adjusted to reflect correct patient.
 PDC Provider discount has been applied.

TOTAL CHARGE:	36,954.65
BENEFITS PAID:	19,305.13
OVERPAYMENT DEDUCTIONS:	(501.20)
TOTAL PAYMENT:	18,803.93
PREVIOUS OVERPAYMENT BALANCE:	15,237.06
NEW OVERPAYMENTS THIS STATEMENT:	501.20
OVERPAYMENTS DEDUCTED THIS STATEMENT:	(501.20)
REFUNDS RECEIVED:	0.00
REMAINING OVERPAYMENT BALANCE:	15,237.06

THIS IS NOT A BILLING. PLEASE SAVE THIS COPY FOR YOUR RECORDS.

COPAYMENT AND DEDUCTIBLES

Types of copayments

Moda Health benefit plans have two types of cost-sharing. The first is a flat fee (i.e., always the same dollar amount for each visit). The second copayment is a percentage of charges, which is sometimes also referred to as “coinsurance.” Both types of copayments show in the “Copay” column on your payment disbursement register (PDR).

The amount of the copayment will depend upon the specifics of the individual member’s plan. The copayment type (a flat fee or a percentage of charges) may vary, depending on the level of benefit. For example, an office visit at the in-network benefit level may have a flat fee copayment of \$10 or \$15, but an office visit to an out-of-network provider may have a larger percentage-of-charges type of copayment.

To determine the amount of copayment for a scheduled service, check the Moda Health online Benefit Tracker or contact our customer service representatives at 503-265-2964 or 888-217-2363.

Multiple copayments per visit

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

Deductibles

Most Moda Health plans also have some type of deductible that is typically applied prior to any copayments and/or coinsurance maximum provisions. The “Patient Responsibility” column on the PDR will include what amount the member is responsible for paying. You can verify if a member has met their deductible for the year by checking Moda Health Benefit Tracker online or contacting our customer service representatives at 503-265-2964 or 888-217-2363.

Collecting copayments and deductibles

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

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 PDR will show if the member has patient responsibility for these amounts at the time your claim is processed.

Moda Health does require that if payments are collected at the time of service and the PDR arrives showing the total amount owed by the patient (patient responsibility field) to be less than the amount that the office has already collected from the patient, the difference must be credited to the patient. If the credited amount is not applied to subsequent visits within a reasonable amount of time, the difference must be refunded to our members.

COORDINATION-OF-BENEFIT INFORMATION

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

A provider agrees to cooperate with Moda Health in presenting claims for payment to other payers, or pursuing claims against other payers, for appropriate application of COB, as set forth in this subsection. In accordance with OAR 836-020-0801 (2)(a)(C), Moda Health, when the secondary payer, may adjust COB payments within two (2) years from the date of the initial estimated payment, should the primary carrier provide actual benefit information.

Per Oregon administrative rules, Moda Health coordinates benefits up to the higher allowable of the two plan amounts. Your payment may be increased in excess of the primary carrier's allowed amount due to this rule.

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

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

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

Please note, self-funded benefit plans, not subject to Oregon State regulations, may direct Moda Health to coordinate benefits differently from state mandates.

Submitting your 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.**

Reimbursement Policy #RPM002, 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. The edits have been clinically determined and validated on a code-by-code basis. 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

The clinical edits are developed, maintained and regularly updated by experienced professional staff, including the Moda Health Medical Director, a large panel of board-certified physicians with specialty-matched expertise, Certified professional coders and registered nurses with expertise in both medical management and clinical care.

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

PROVIDER INQUIRIES AND APPEALS

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 877-605-3229. If the Customer Service team is unable to resolve the issue to the provider's satisfaction, the provider will be advised of their right to dispute the decision as described below.

Inquiry

The first time a request for review is submitted to the appeals team, it will always be considered an inquiry. A written request for information regarding claim status, member eligibility, payment methodology (including bundling/unbundling, multiple surgery rules, etc.), medical policy, coordination of benefits or third party issues are examples of provider inquiries. 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 45 business days of receipt of the inquiry and notification of the provider's right to the next step in the appeal process. If the provider disagrees with the Moda Health determination in response to the inquiry, 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.

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 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
- An explanation of the issue the provider believes is incorrect, including supporting medical records or documentation when applicable
- For claims involving coordination of benefits, the name and address of the primary carrier

Inquiries and appeals should be submitted to:

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

MEMBER APPEALS

Moda Health provides an internal multilevel procedure for members to obtain timely resolution of their appeals. The statutes and regulations that govern the member's medical plan determine the levels of review of the appeal. On group plans, the final level of review with Moda Health is a second-level appeal. Individual plans have one level of appeal, and eligible plans will go to external review. Persons not involved in any previous decisions review each level of appeal. The member must file the appeal within the timeframe specified in the member's plan handbook.

Receipt of a member appeal is acknowledged by Moda Health in writing within seven calendar days. A written response is sent to the member within the timeframe specified in the member's plan handbook. An appeal regarding an urgent care request is expedited.

The Moda Health 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. For group plans, the written response also provides information on the member's right to an additional appeal through Moda Health, and if applicable, the right to request an external review, file a complaint with the Oregon Insurance Division, or file a lawsuit in court. This does not apply to individual plans.

Providers can appeal on behalf of a member (with the member's permission) regarding medical necessity, prior authorization and referral issues. The member must sign and submit an authorization for Moda Health to allow the provider to appeal on their behalf or release information regarding our determination on the appeal.

RECOVERY OF OVER/UNDERPAYMENTS TO PROVIDERS

Either party will be entitled to request an adjustment of payment if they notify the other of an overpayment or underpayment within 18 months following the date of payment in question. The aforementioned 18 month limitation does not apply in cases involving coordination of benefits, claims involving fraud or certain claims involving subrogation. Any request for a corrective adjustment must specify the reason as to why the requesting entity believes it is entitled to an adjustment. For claims involving coordination of benefits, the request for refund must be made within 30 months after the date that the payment was made, and any such request must specify the reason the party believes it is owed the refund or additional payment. It must include the name and mailing address of the entity that has primary responsibility for payment of the claim or who has disclaimed responsibility for payment of the claim.

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

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 503-265-2964 or 888-217-2363 to resolve the matter.

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" 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 503-265-2964 or 877-337-3229, 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 PDR 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.
Appeal Unit
P.O. Box 40384
Portland, OR 97240

THIRD PARTY LIABILITY (SUBROGATION)

Definitions

Third-Party Liability (TPL)

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

Subrogation

Means the assumption of another's legal right to collect a debt or damages. For example, when 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 that portion of the debt or damages resulting from the illness or injury. 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.

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:

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 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."

AFTER-HOURS CARE

The provider must be accessible 24 hours a day, seven days a week. The provider is responsible for establishing an on-call arrangement with another 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.

CREDENTIALING AND RECREDENTIALING OF MODA HEALTH PHYSICIANS AND ALLIED HEALTH PROFESSIONALS (PROVIDERS)

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

Participating on the Moda Health Provider Panel:

Participation Criteria

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

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

Who Requires Credentialing?

- Refer to the provider classification table set forth herein.

- A *locum tenens* of 91 or more calendar days of service who is new to the Moda Health panel is required to complete a credentialing application. If already credentialed by Moda Health, they submit the documents listed below.
- If 90 calendar days or less of service, a provider is not required to complete a full application but must submit a letter including:
 - Full name
 - Other names used
 - Date of birth
 - Social Security number
 - Practice and billing information
 - Copies of state licensure, malpractice insurance coverage, DEA certificate (if applicable) and completed attestation attached to the initial application
 - Name of medical school, degree received and year of graduation.
 - Completed and signed OPCA attestation and authorization to release information pages

Primary Care Providers (PCP) Status:

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

Application Required:

- **Credentialing**
 - A provider new to the Moda Health panel
 - A returning provider whose contract was terminated and a new contract is not put in place within 30 days
 - A *locum tenens* providing services for 91 calendar days or longer
- **Recredentialing**
 - An established provider completes one within three (3) years from the last application approval date. This is required to continue participating on the Moda Health panel. Moda Health will remind the provider by mailing the application to the provider.
 - An established provider who has returned from a leave of absence and is requesting within three years to be reinstated
 - A provider who was on a Moda Health panel through a delegated entity and is requesting direct participation on the panel

Application Forms Accepted:

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

Moda Health does not accept, and will return, applications that:

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

Helpful Hint:

An electronic Microsoft Word version of the OPCA and OPRA can be downloaded from the Oregon Health Plan Policy and Research website at:

www.oregon.gov/oha/OHPR/ACPCI/pages/state_app.aspx

The Application and Attestation

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

These include:

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

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

The Attestation Statement Addresses:

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

Helpful Hint:

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

Returning the Application:

Moda Health
Attn: Provider Credentialing – 8th Floor
601 S.W. 2nd Avenue
Portland, OR 97204

Primary Source Verification of Credential Application Elements

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

Application Elements Related to the Provider that May Be Subject to Verification Include the Following:

- Current and past state license/s
- DEA certificate
- Malpractice insurance coverage or letter of intent from the malpractice insurance carrier
- Hospital affiliation or receipt of a documented admitting process with other Moda Health participating providers
- Current practice information
- Gaps in work history of two (2) months or more
- Work history
- Medical, dental or undergraduate education from an accredited school

- Education Commission for Foreign Medical Graduates (ECFMG) certificate
- Postgraduate training (i.e. internship, residency, etc.)
- Board certification
- Malpractice claim history of last five (5) years, three (3) years for recredentialing
- Medicare/Medicaid sanctions/exclusions
- State license sanctions of last five (5) years, three (3) years for recredentialing
- Additional administrative data relating to a provider's ability to provide care and service to Moda Health members
- National Provider Identifier, type 1- Individual

Discrepancy in Credentialing Information

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

- Moda Health notifies the applicant in writing of the discrepancy and requests a written explanation within fourteen (14) calendar days. The response is reviewed by the medical director or the Moda Health credentialing committee.
- If the applicant does not respond within fourteen (14) calendar days, the Moda Health credentialing supervisor contacts the physician by telephone requesting a response in writing within seven (7) calendar days.
- If no response is received, the application process is terminated and the applicant is notified via certified letter.

Application Approval or Denial

The Moda Health medical director or Moda Health credentialing committee will review the application information and decide to:

- Approve the application.
- Approve the application but request additional information. The provider is monitored until the requested information is reviewed.
- Pend the application and request additional information to be reviewed at a future committee meeting. The applicant is monitored as a pending applicant.
- Deny the application completely. Only the committee is authorized to make this decision.

Moda Health will notify the provider or appropriate credentialing contact person in writing within thirty (30) calendar days of the medical director's or credentialing committee's decision.

Provider Rights

Providers have the right to:

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

Provider Appeal of Adverse Action

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

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

Confidentiality

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

MODA HEALTH PROVIDER CLASSIFICATION TABLE

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
Medical Physicians	DC - Doctor of Chiropractic Medicine	All specialties Psychiatry	Contract – Yes Credential – Yes
	DO - Doctor of Osteopathic Medicine	Radiologist, pathologist or anesthesiologist who are providing services to independent physicians who are practicing in an outpatient setting	Not applicable – Physicians who are not contracted directly with Moda Health through an individual, clinic, medical group and/or independent physician association
	DPM - Doctor of Podiatric Medicine		
	MD - Doctor of Medicine		Physicians accessed through a delegated third-party panel
	ND - Doctor of Naturopathic Medicine		Providers practicing in an inpatient setting. See below
	OD - Doctor of Optometry		Providers applying for PCP designation must: <ul style="list-style-type: none"> • Completed 3 year Residency at an accredited program • Or be board certified in a PCP eligible specialty by ABMS or AOA. • Have a DEA or prescribe plan • Hospital Admitting privileges or an admit plan • 24/7 PCP call coverage • If the criteria above is not met, the provider must be listed as a specialist.

Practitioner Classification	Degree/Title	Specialty	Contract Credential Comments
Allied Health Professionals	CNM - Certified Nurse Midwife (CNM, NP and RN licensed) LAc - Licensed Acupuncturist NP - Nurse Practitioner CRNA - Certified Registered Nurse Anesthetist PA - Physician Assistant PT/OT - Physical or Occupational Therapist LMP - Licensed Massage Practitioner RD - Registered Dietician MA/MS - Speech & Language Pathology/Audiology, Hearing Aid Specialists Mental Health Providers – see below	Alternative Medicine: <ul style="list-style-type: none"> ▪ Naturopath ▪ Homeopath ▪ Acupuncture Midwifery: <ul style="list-style-type: none"> ▪ Certified Nurse Midwife (with active NP and RN license) ▪ Nurse Midwife ▪ Nurse Practitioner ▪ Registered Nurse Speech/Language Pathology, Audiology Hearing Aid Specialists Nurse Practitioner (NP) specialties that can practice as a PCP: <ul style="list-style-type: none"> ▪ ACNP - Acute Care ▪ ANP - Adult ▪ FNP - Family ▪ GNP – Geriatric ▪ NMNP – Nurse Midwife ▪ NNP - Neonatal ▪ PNP - Pediatric ▪ WHCNP - Women’s Health Care CRNA – Certified Registered Nurse Anesthetist, outpatient practice only Therapist specialties: <ul style="list-style-type: none"> ▪ Occupational ▪ Physical ▪ Massage (7/1/2014) RD – Registered Dietician (7/1/2014)	Contract – Yes Credential – Yes

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

		Public Health Dental Hygienists with LAP/Extended-Practice Permit only.	
Locum Tenen Please contact credentialing@modahealth.com for more information on credentialing Locum Tenen's.	All degrees	All specialties	Contract – Yes Credential – Yes
Providers Not Requiring Credentialing Providers practicing in an in-patient setting; see below Dentist who provides primary dental care only under a dental plan or rider.	RN - Registered Nurse RNFA - Registered Nurse First Assist	Other: <ul style="list-style-type: none"> ▪ Anesthesiologist Assistant ▪ Biofeedback ▪ Cardiovascular (Clinical) Perfusionist ▪ Cardiovascular Technologist ▪ Diagnostic Medical Sonographer ▪ Electroneurodiagnostic Technologist ▪ Non-physician Surgical Assistant 	Contract – Yes Credential – No
In-patient Setting Only Employees or Providers Practitioner who practices exclusively within the inpatient setting (health delivery organizations) and provides care only as a result of Moda Health	All degrees	Inpatient settings (health delivery organizations) <ul style="list-style-type: none"> ▪ Employees ▪ Radiologist* ▪ Pathologist* ▪ Anesthesiologist only ▪ Neonatologists ▪ ER physicians ▪ Behavioral Health ▪ Nurse Anesthetist <p>* If the radiologist or pathologist is also offering services to independent</p>	Contract – Yes Credential – No Contract and credential the hospital or facility – see Credentialing Health Care Delivery Organizations

<p>members being directed to the inpatient setting</p> <p>Practitioner who does not provide care for members in a treatment setting (e.g., board-certified consultants)</p>		<p>physicians who are practicing in an out-patient setting, they must be credentialed. See <i>Medical Physicians</i> above.</p>	
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MEDICAL RECORD, OFFICE SITE, ACCESS AND AFTER-HOUR STANDARDS AND AUDITS

Practice Standards — NCQA Compliance

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

Practitioners subject to audits:

- All practitioners
- All specialties

Noncompliant Practitioners:

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

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

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

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

Medical Records Standards

Standards for all medical record-keeping systems

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

Office Site Standards

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

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

PRIVACY AND SECURITY STANDARDS

The following privacy and security standards are required:

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

PHYSICAL ACCESS

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

TIMELY ACCESS

To ensure that Moda 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 30 calendar days of the request.

Behavioral Health appointment standards are:

- Member requiring urgent care are seen within two calendar days.
- 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.

SPECIAL INVESTIGATIONS UNIT

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 his or her 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.

CARE COORDINATION AND CASE MANAGEMENT

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

On site, the Moda Health medical management manager and medical directors provide guidance to and oversight of the nurses providing case management services and care coordination.

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

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

Referrals to Case Management

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

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

To make a referral to case management, call Healthcare Services at 503-948-5561 or toll-free 800-592-8283, or fax a request to 503-243-5105. For your convenience, you can access a case management referral form on the provider website at www.modahealth.com.

The following information is needed:

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

Repatriation of Individual Beacon Members

Moda Health is partnered with OHSU to pilot a workflow to “repatriate” members admitted to an out-of-network (OON) facility’s emergency department (ED) to initiate a safe transfer of the member to an OHSU or OHSU-affiliated hospital when possible. **Repatriation** means the process of coordinating a transfer of a member from an out-of-network facility to an in-network facility.

Effective January 2019, this pilot project will be applicable to only

- Moda members enrolled in an Individual Beacon network plan
- Moda members who live in Clackamas, Multnomah, or Washington counties; AND
- Admitted to an OON facility within Oregon’s Clackamas, Multnomah, and Washington counties, or Clark County, Washington.

Members admitted to an OON facility will be transferred **ONLY** if it is deemed safe to transport. If a member’s condition is not stable enough for a transfer, the Moda RN Care Coordinator should make an exception for member to stay at the OON facility. Moda is working with **OHSU’s Mission Control** department, comprised of a team of physicians, Transfer Case Nurses, and operational staff who will work with Moda to monitor Moda members admitted to OON facilities, initiate and coordinate a transfer when the OON Hospital Attending Physician and OHSU Physician on Duty has determined whether the member’s condition is stable.

Why is Moda doing this?

Beginning in 2019, Oregon Individual Plans have an Exclusive Provider Organization plan design with a narrowed network and generally no out-of-network coverage (except in emergency care situations). Supporting the member’s transition from an OON facility to an in-network facility (OHSU, Tuality Healthcare, Adventist Health), helps the member continue to receive care under covered plan benefits. This process should lower out-of-pocket costs for the member by directing them to an in-network facility, when possible, for the majority of an inpatient admission.

Who may be repatriated:

- Oregon Individual members in a Beacon network plan
- Members admitted to an OON facility Emergency Department **within** Clackamas, Multnomah, or Washington counties, or Clark County, Washington
- Eligible in-network health systems: **OHSU Hospital, Adventist Health, or Tuality Healthcare**
- Beacon members receiving emergency care

Who may not be repatriated:

- Oregon Individual members, enrolled in a plan with the Affinity and Cornerstone network
- Members admitted to an OON facility **outside** Oregon’s Clackamas, Multnomah, and Washington counties, or Clark County, Washington. Members transferred to in-network facilities that are **not an OHSU-affiliated hospital**

- Scheduled procedures for non-emergent care
- Behavioral health admissions

DISEASE MANAGEMENT

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

Moda Health notifies providers when their patients enroll in one of our disease management programs. Providers are asked if Moda Health can offer additional assistance with co-morbid conditions in order to help their patients achieve optimal health status. Moda Health also provides chart-ready follow-up reports on each patient. If you would like to refer a patient to Moda Health for disease management, please contact us at careprograms@modahealth.com, or by phone at 503-948-5548; toll-free at 877-277-7281.

Conditions covered through coaching:

- Asthma
- Chronic obstructive pulmonary disease
- Cardiovascular risk factors
- Depression
- Diabetes
- Maternity
- Chronic pain

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

- Childhood immunization
- Health screenings
- Oral health
- Patient safety

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

Program Goal

The goal of Moda Health’s Quality Improvement (QI) program is to advance the “triple aim” for our members.

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 within 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

Moda Health meets these objectives by focusing 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.

Scope of Service and Issues Reviewed

The Medical Quality Improvement Committee 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-specific or Provider-specific data in accordance with the organization's confidentiality and privacy 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.

VALUE-BASED CARE QUALITY MEASURES AND BENCHMARKS

Synergy Shared Risk Model Quality incentive pool

Participating PCP practices will be eligible for a quality incentive payment based on their performance in meeting or exceeding the quality measure benchmarks. The Quality Incentive Pool will be measured for calendar years of service beginning January 1, 2018. Quality incentive payments due to eligible primary care practices will be distributed as part of the settlement distribution. The funding for the Quality Incentive Pool will be 1.00% of Pure Premium for each region.

For each metric, the number of Synergy Member-months in a region will be divided into the Quality Incentive Pool for that region to determine the total amount of per member per month (pmpm) incentive dollars. Each Participating PCP clinic will be eligible for an incentive equal to:

$(\# \text{ of Synergy Member Months}) \times (\text{Incentive } \$ \text{ Per Member Per Month}) \times (\# \text{ of reportable measures that met Benchmark})$

Moda Health recognizes that not all measures are applicable to all practices. For example, an internal medicine clinic would not be expected to influence Developmental Screening. In order for a measure to be reportable, a clinic must have at least thirty eligible members in the denominator for that measure. For example, if a practice did not have at least thirty continuously enrolled members age 12-21 assigned, they would not receive a score for the AWC measure, and their measure set would be 13, rather than the total 14 measures. This will ensure practices will not be penalized for measures they are not able to influence based on their patient population. With respect to measures with Benchmarks requiring “Data Submission Only”, these will be scored as pass/fail based on receipt of data for the applicable measure; no minimum membership is required.

A complete list of 2018 Synergy Shared Risk Model Quality Measures and Benchmarks can be found [here](#).

VALUE-BASED CARE DATA DICTIONARY AND ELEMENTS

As part of the Value Based Care data sharing arrangement, Participating Providers shall use best efforts to comply with Moda's requests to share clinical, quality, EMR and other data to facilitate care coordination. Information that will be shared may include but is not limited to, medical records, investigation of complaints, utilization review, quality assessment, preventative health care, outcome studies and data collection from monitoring and evaluation of health care service and delivery for Moda members.

The EHR Data Dictionary and Requested Data Elements which can be downloaded [here](#), provides formatting guidelines for the Quality Measure data submission.

TELEPHONE AUTHENTICATION

In order to protect the privacy of our Member information, Moda Health requires that our customer service representatives authenticate callers inquiring about Member information. For the physician office, the following information will be requested when a Provider office calls in:

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

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

PATIENT PROTECTION ACT

The Patient Protection Act, also known as Senate Bill 21, was passed by the 1997 Oregon State Legislature to assure, among other things, that patients and Providers are informed about their health insurance plans. To that end, Moda Health provides this question and answer section to outline some important terms and conditions of our plans.

What are a Member's rights and responsibilities?

Members have the right to:

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

Members have the responsibility to:

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

Members who have any questions about these rights and responsibilities can call the Moda Health Medical Customer Service department.

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

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

There are exceptions to the referral requirement under a PCP plan. A referral is not needed for emergency medical treatment or for a woman using the services of a participating women’s healthcare provider for either a routine women’s exam or for routine pregnancy care. A referral is not needed for chemical dependency or mental health treatment. The member handbook contains more information regarding service authorizations for chemical dependency and mental health.

What does the member do in a medical emergency?

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

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

The member handbook contains additional information regarding emergency care.

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

It is the responsibility of the employer to notify a member of benefit changes or termination of coverage. If the group contract terminates and the employer does not replace the coverage with another group contract, the employer is required by law to inform the member in writing of the termination.

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

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

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

A member can file a grievance or appeal by contacting our Medical Customer Service department. The member can also write a letter to Moda Health at P.O. Box 40384, Portland, Oregon 97240-0384. The member handbook section titled "Complaints, Appeals, and External Review" contains complete information.

The member may also contact the Oregon Insurance Division:

By calling: 503-947-7984 or 888-877-4894
By writing: Oregon Insurance Division
Consumer Protection Unit
P.O. Box 14480
Salem, Oregon 97309-0405
Online: www.oregon.gov/DCBS/insurance/gethelp/
Email: cp.ins@state.or.us

What are your prior authorization and utilization review criteria?

Prior authorization is the process we use to determine whether a service is covered under the plan (including whether it is medically necessary) prior to the service being rendered. Contact our Medical Customer Service department for a list of services that require service

authorization. Many types of treatment may be available for certain conditions; the service authorization process helps determine which treatment is covered under the plan.

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

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

Moda Health medical necessity criteria, along with a description of how they are developed, is available for your review at www.modahealth.com/medical. You may also request a printed copy of specific criteria by calling 503-243-4496.

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

Moda Health protects a member’s information in several ways:

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

How can a member participate in the development of Moda Health’s corporate policies and practices?

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

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

Moda Health
Healthcare Services
601 S.W. Second Avenue
Portland, Oregon 97204
www.modahealth.com

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

Call the Moda Health Medical Customer Service department or Pharmacy Customer Service. One of our representatives will coordinate the services of an interpreter over the phone.

What additional information can a member get upon request?

The following documents are available by calling a Medical Customer Service representative:

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

What information can a member get about Moda Health from the Oregon Insurance Division?

The following information regarding Moda Health plans is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.
- A summary of our health promotion and disease prevention activities.
- An annual summary of grievances and appeals.
- An annual summary of utilization review policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

Contact:

Oregon Insurance Division
Consumer Protection Unit
P.O. Box 14480
Salem, Oregon 97309-0405
503-947-7984 or 888-877-4894
Email: cp.ins@state.or.us
www.oregon.gov/DCBS/insurance/gethelp/

What is provider risk sharing?

Under a risk-sharing arrangement, the providers that are responsible for delivering healthcare services are subject to some financial risk or reward for the services they deliver. Contact Moda Health for additional information.

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

We have been very careful to comply with the requirements of HIPAA, HITECH, and the requirements of other federal and state law related to privacy and security of member information. We are also aware that as the law changes or as interpretations of the rules become more clear, we will need to continue to make changes in order to remain compliant. Should you have any questions regarding HIPAA and/or HITECH compliance, be it privacy, electronic transactions and code sets or security, please do not hesitate to contact the Moda Health EDI/Privacy/Security Office at 503-243-4492.

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.

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

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

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

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

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.

Centers for Medicare and Medicaid Services (CMS) — Formerly known as HCFA (Healthcare Financing Administration), 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.

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. The edits have been clinically determined and validated on a code-by-code basis.

CMS 1500 — A universal form for providers of services to bill professional fees to health carriers. It is also known as the Uniform Health Insurance Claim Form. By law, it must be used for claims submitted to 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.

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 employer-sponsored group health plan.

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

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.

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.

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-9 and ICD-10, as applicable, are also 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.

Effective Date — The date a contract becomes active.

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

Electronic Remittance Advice (ERA) — An electronic statement sent to providers that outlines how a payer adjudicated a claim and paid for services. This is the electronic version of 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 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.

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.

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.

First Choice Health Network Inc. (FCHN) — First Choice Health Network is a Washington company owned by hospitals and providers throughout Washington. First Choice Health Network contracts with hospitals, physicians and other providers in Washington, Alaska, Montana and Idaho.

Focus List — A listing of services requiring authorization for all commercial plans.

Grievance — Any issue or concern expressing dissatisfaction with products, services, operations and/or protocol from a customer, state insurance department or other party on behalf of a customer.

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 — Any hospital expense, medical expense or hospital and medical expense policy or certificate, healthcare service contractor or health maintenance organization subscriber contract, any plan provided by a multiple-employer welfare arrangement, or other benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

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.

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

INNET Beacon Hospital — OHSU, Tuality Healthcare, and Portland Adventist Health Hospitals

International Classification of Diseases — 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-9 and ICD-10, as applicable, are also referred to as a diagnosis codes.

Idaho Physicians Network (IPN) — IPN's coverage includes 34 of the 44 counties throughout the state. IPN has extensive network coverage throughout the southwestern and southeastern parts of Idaho and is currently working on expansion into Northern Idaho to complete its statewide network.

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 other than a facility is the lesser of supplemental provider fee arrangements Moda Health may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database. If a dollar value is not available in the national database, Moda Health will consider 75% of the billed charge as the MPA. In certain instances,

when a dollar value is not available in the database, the claim is reviewed by Moda Health's medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

MPA for out-of-network facilities such as hospitals, ambulatory surgical centers, home health providers, skilled nursing facilities and residential treatment programs is the lesser of supplemental facility or provider fee arrangements Moda Health may have in place, 125% of the Medicare allowable amount based on data collected from the Centers for Medicare and Medicaid Services (CMS), or the billed charge.

MPA for end-stage renal disease (ESRD) facilities is 125% of the Medicare allowable amount.

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 medical devices, including implanted devices, and for durable medical equipment is the contracted amount, or the lesser of 100% of the Medicare allowable amount or the acquisition cost of the device plus 10% if there is no contracted amount.

MPA for prescription medications is no more than the prevailing pharmacy network fee based on the average wholesale price (AWP) accessed by Moda Health minus a percentage discount. Reimbursement for medications dispensed by all other providers will be subject to benefit provisions of the Plan and paid based on the lesser of either AWP or billed charges.

Medical Services Contract — A contract (1) between an insurer and an independent practice association, (2) between an insurer and a provider, (3) between an independent practice association and a provider or organization of providers, (4) between medical or mental health clinics, and (5) between a medical or mental health clinic and a provider to provide medical or mental health services. A medical services contract does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

Medically Necessary — Services and supplies that are required for diagnosis or treatment of illness or injury and which, in the judgment of Moda Health, are:

- Appropriate and consistent with the symptoms or diagnosis of the member's condition;
- Established as the standard treatment by the medical community in the service area in which they are received. Not primarily for the convenience of the member or a physician or provider of services or supplies; and
- The least costly of the alternative supplies or levels of service that can be safely provided to the member. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the patient's home without harm to the patient.

Medically necessary care does not include custodial care.

Note: *The fact that a physician or provider prescribes, orders, recommends or approves a service or supply does not, of itself, make the service medically necessary or a covered service.*

Member — An employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

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 Behavioral Health — Provides managed behavioral healthcare services to individuals covered by Moda Health managed care, PPO and POS policies.

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.

The **Connexus Network** (formerly ODS Plus) is a directly contracted group of most provider types in Oregon and Southwest Washington.

The **Endeavor Select network** is the Moda Health Medical Provider Network in Alaska. Providers participating in this network are directly contracted with Moda Health. Moda Health members enrolled in the Endeavor Select network who elect to receive medical services in Oregon may see any providers participating in the Connexus network and their claims will be paid at the in-network benefit level.

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.

OHSU Mission Control — A hospital operations team acting as the main point of contact for repatriation cases. The team is comprised of physicians, transfer case RNs, and operational staff.

Oregon Practitioner Credentialing Application (OPCA) — A statewide application created by the ACPCI that may be used by Oregon hospitals and health plans for credentialing. It was created November 2000 and revised May 2012.

Oregon Practitioner Recredentialing Application (OPRA) — A statewide application created by the ACPCI that may be used by Oregon hospitals and health plans for recredentialing. It was created November 2000 and revised May 2012.

Organizational Provider Credentialing Application — An application created in April 2003 by the Oregon Health Plan Networking Group, which may be used by health plans for credentialing a facility.

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-Pocket (OOP) — The amount a member pays for services, which includes copays and coinsurance. Certain expenses do 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 and PPO — Hospitals, physicians, providers, professionals and facilities that have contracted with Moda Health to provide benefits to persons covered under this plan.

Participating Hospital — A contractual relationship between a health plan and one or more hospitals where the hospital provides inpatient care/services covered by the health plan.

Patient Responsibility — The amount the patient is responsible to pay for the services received. This amount includes disallowed charges, deductibles and copayments.

Payment Disbursement Register (PDR) — 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.

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

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

PreManage — A licensed web application owned by Collective Medical Technologies used by facility Emergency Departments and health insurers to track and notify patient admissions.

Primary Care Physician (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.

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.

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.

Professional Relations — A department of Moda Health that is responsible for maintaining provider demographic information and online directories.

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 and maintaining provider relationships.

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

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

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

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.

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.

Repatriation — the process of coordinating a transfer for a member from an out-of-network facility to an in-network facility.

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.

TC RN — OHSU Transfer Case RN, part of the Mission Control team, who works with the out-of-network facility, member, and Moda HCS staff to coordinate transfers to an in-network facility.

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

Third-Party 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.

Tri-county Area — Oregon's Clackamas, Multnomah, and Washington counties

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.

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.

ACRONYMS

AC	Acupuncturist
ACPCI	Advisory Committee on Practitioner Credentialing Information
ALOS	Average Length Of Stay
ANP	Adult Nurse Practitioner
ANSI	American National Standard Institute
ARNP	Advanced Registered Nurse Practitioner
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
ASO	Administrative Services Only
AuD	Audiology Doctorate
AWP	Average Wholesale Price
BA	Bachelor of Arts Degree
BS	Bachelor of Science Degree
BSN	Bachelor of Science Nursing
CA, CAc	Certified Acupuncturist
CAMT	Certified Acupressure Massage Therapist
CDE	Certified Diabetes Educator
CF	Conversion Factor
CHt	Clinical Hypnotherapist
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
CMT	Certified Massage Therapist
COB	Coordination Of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CRT	Certified Respiratory Therapist
CSN	Certified School Nurse
CST	Certified Surgical Technologist
CWS	Certified Wound Specialist
DC	Doctor of Chiropractic
DDS	Doctor of Dental Surgery
DHHS	Department of Health and Human Services
DMD	Doctor of Medical Dentistry
DME	Durable Medical Equipment
DO	Doctor of Osteopathy
DOB	Date Of Birth
DOS	Date Of Service
DPM	Doctor of Podiatric Medicine

DRG	Diagnosis-Related Group
DTR	Dietetic Technician Registered
DX	Diagnosis Code
EAP	Employee Assistance Program
EdD	Degree in Education
EDI	Electronic Data Interchange
EMT	Emergency Medical Technician
EOB	Explanation Of Benefits
ER	Emergency Room
ERISA	Employee Retirement Income Security Act of 1974
FCHN	First Choice Health Network
FFS	Fee For Service
FNP	Family Nurse Practitioner
FUD	Follow-Up Days
GNP	Geriatric Nurse Practitioner
HCFA	Healthcare Financing Administration — see CMS
HCPCS	Healthcare Common Procedural Coding System
HEDIS	Health Plan Employer Data Information Set
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD-9-CM	International Classification of Diseases, 9th Edition
ICD-10-CM	International Classification of Diseases, 10th Edition
ICF	Intermediate Care Facility
INF	Infertility
IPA	Independent Practice Association
IPN	Idaho Physicians' Network
LAc	Licensed Acupuncturist
LCSW	Licensed Clinical Social Worker
LLP	Limited Licensed Practitioner
LMFT	Licensed Marriage & Family Therapist
LMP	Licensed Massage Practitioner
LMT	Licensed Massage Therapist
LN/LNC	Licensed Nutritionist/Counselor
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LPT	Licensed Physical Therapist
LSW	Licensed Social Worker
MA	Master of Arts
MAc	Masters in Acupuncture
MD	Medical Doctor
MFCC	Marriage, Family and Child Counselor
MFT	Marriage and Family Therapist
MH	Master Herbalist

MHNP	Mental Health Nurse Practitioner
MMA	Mountain Medical Affiliates
MPA	Maximum Plan Allowance
MS	Master of Science
MSN	Master of Nursing
MSW	Master of Social Work
NANP	Not Accepting New Patients
NCQA	National Committee for Quality Assurance
ND	Naturopathic Doctor
Non-Par	Non-Participating
NP	Nurse Practitioner
OD	Doctor of Optometry, Optometrist
Moda Health	Multi-faceted organization with a full line of affordable health plans
OOA	Out of Area
OON	Out of Network
OOP	Out of Pocket (costs)
OPA	Orthopedic Physician's Assistant
OPCA	Oregon Practitioner Credentialing Application
OPRA	Oregon Practitioner 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