2020 Provider Workshop

Presented by Moda Health

Welcome

Alternative Care

Chiropractic, Acupuncture, Massage Therapy, PT, OT, ST

Agenda

- Healthcare Services/EviCore
- Reconsiderations and Appeals
- Telehealth Expansion
- Commercial Networks/Membership
- Claims/Multiple Procedure Reduction
- Medicare Advantage Updates

Healthcare Services

Healthcare Services
eviCore

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

modahealth.com/medical/utilizationmanagement.shtml

Healthcare Services

Therapy CorePath

Therapy CorePath

- For musculoskeletal therapies

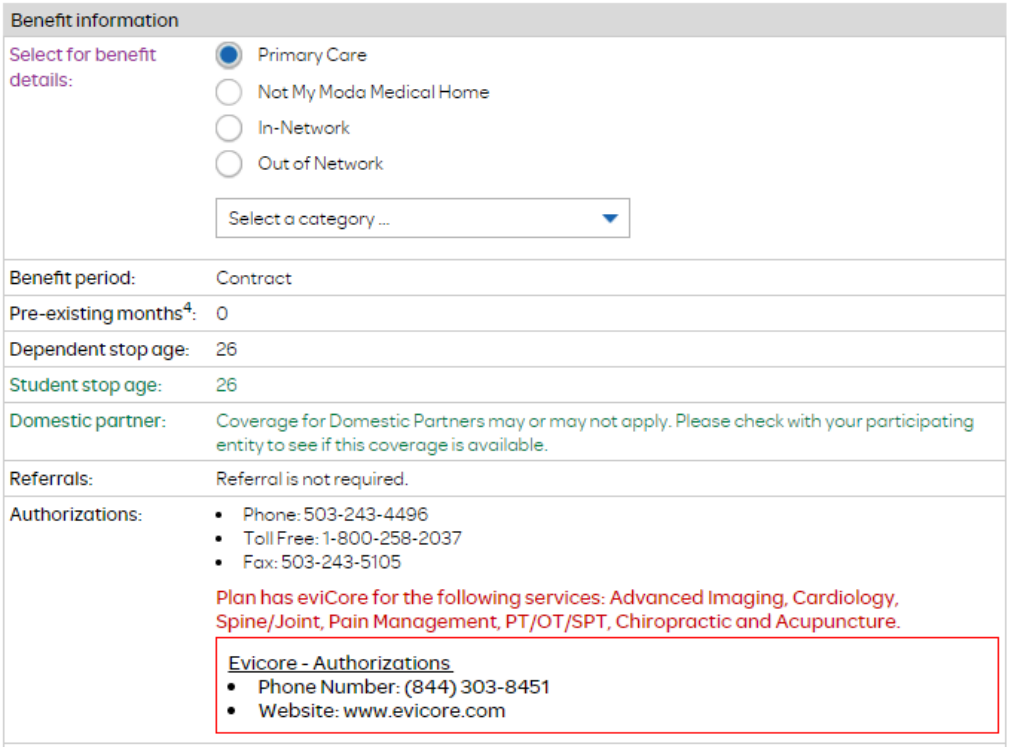
- In early 2020 the initial visit allocation was increased from 30 days to 90 days.

- Authorization of additional visits based on each patients confirmed progress

Healthcare Services

eviCore

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



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

Healthcare Services
Worksheets/Guidelines

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

Clinical Guidelines
eviCore

Provider's Hub

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

Clinical Guidelines

eviCore

Authorization Denials

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

Reconsiderations and appeals

Moda Reconsiderations and appeals
Provider reconsiderations

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

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

Reconsiderations and appeals

Written or verbal request

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

Reconsiderations and appeals

Same specialty request

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

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

Reconsiderations and appeals

Peer-to-peer consultation

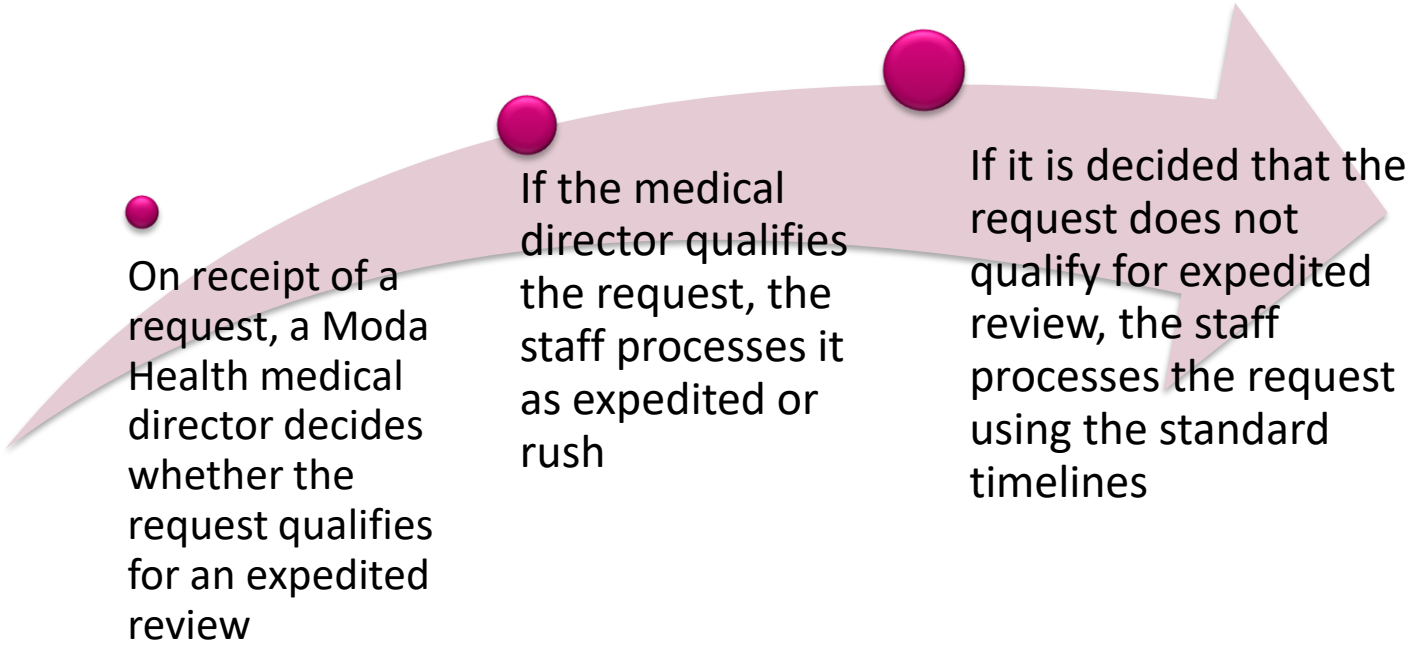
A peer-to-peer consultation is a conversation between the requesting provider and the Moda Health medical director.

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

Reconsiderations and appeals

Expedited or rush requests

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



Reconsiderations and appeals

Provider appeals

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

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

Reconsiderations and appeals

Member appeals

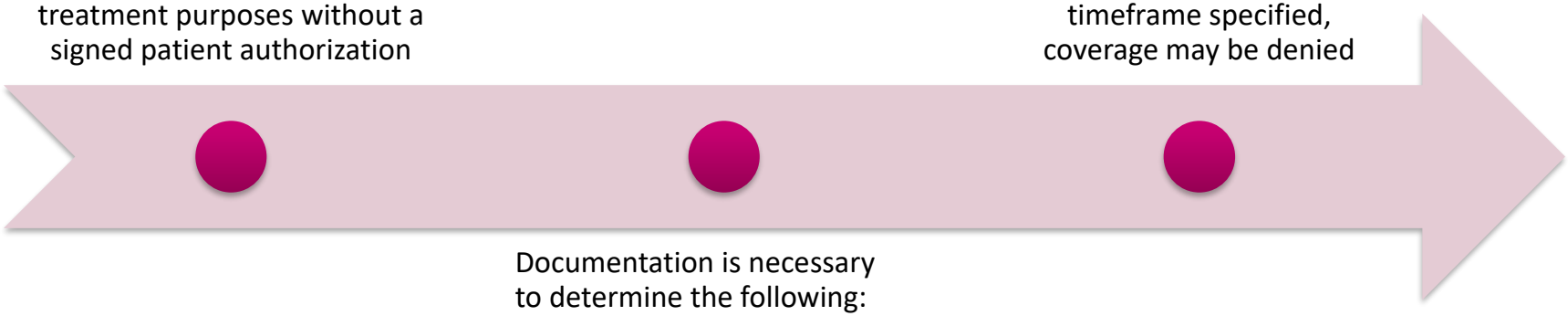
A member appeal is a pre-service or post-service appeal initiated by a member regarding an adverse determination on an authorization request or a claim.

- A provider may file a pre-service member appeal on behalf of a member in writing
- The commercial or marketplace member must complete a Moda Health Protected Health Information form

Reconsiderations and appeals

Medical record requests

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



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

Documentation is necessary to determine the following:

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

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

Telehealth Services

Expansion

Telehealth – Temporary COVID-19

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

Telehealth Coding

Neuro/Cognitive Services

- 96116, 96125, 96130-96139

Speech Therapy

- 92507-92508, 92521-92524, 96105, S9152

Physical Medicine and Rehabilitation (PT, OT, etc.)

- 97110, 97112, 97116, 97161-97168, 97535, 97750, 97755,97760, 97761

Commercial networks

2021 Commercial networks

2021 Commercial Networks -Group

Connexus

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

Synergy

- Coordinated care plan for employer groups offered statewide

2021 Commercial Networks - Group

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

2021 Commercial Networks - Individual

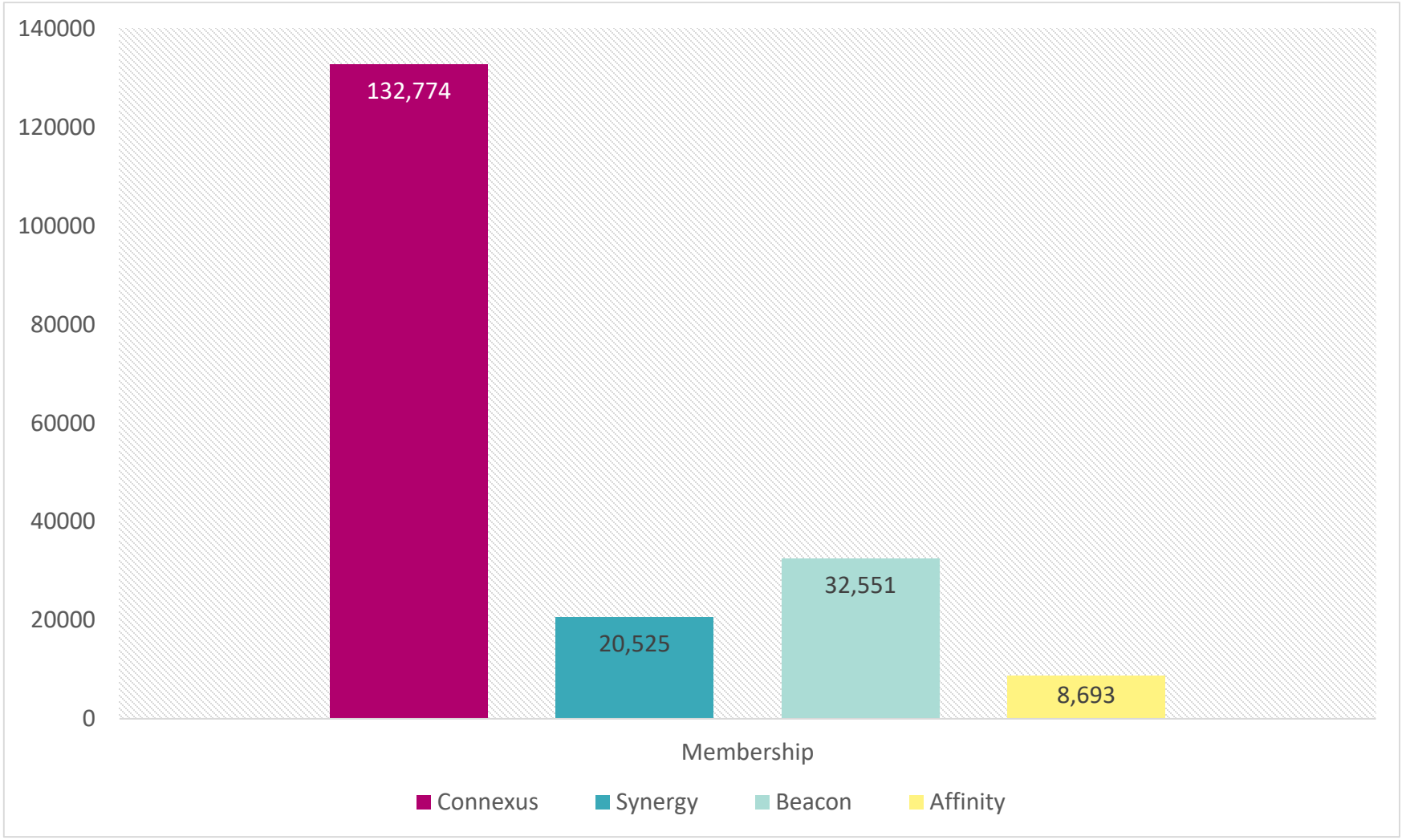
Beacon

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

Affinity

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

Commercial Membership



Commercial PPO networks

Connexus

Small and Large Group plans

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

Synergy Network

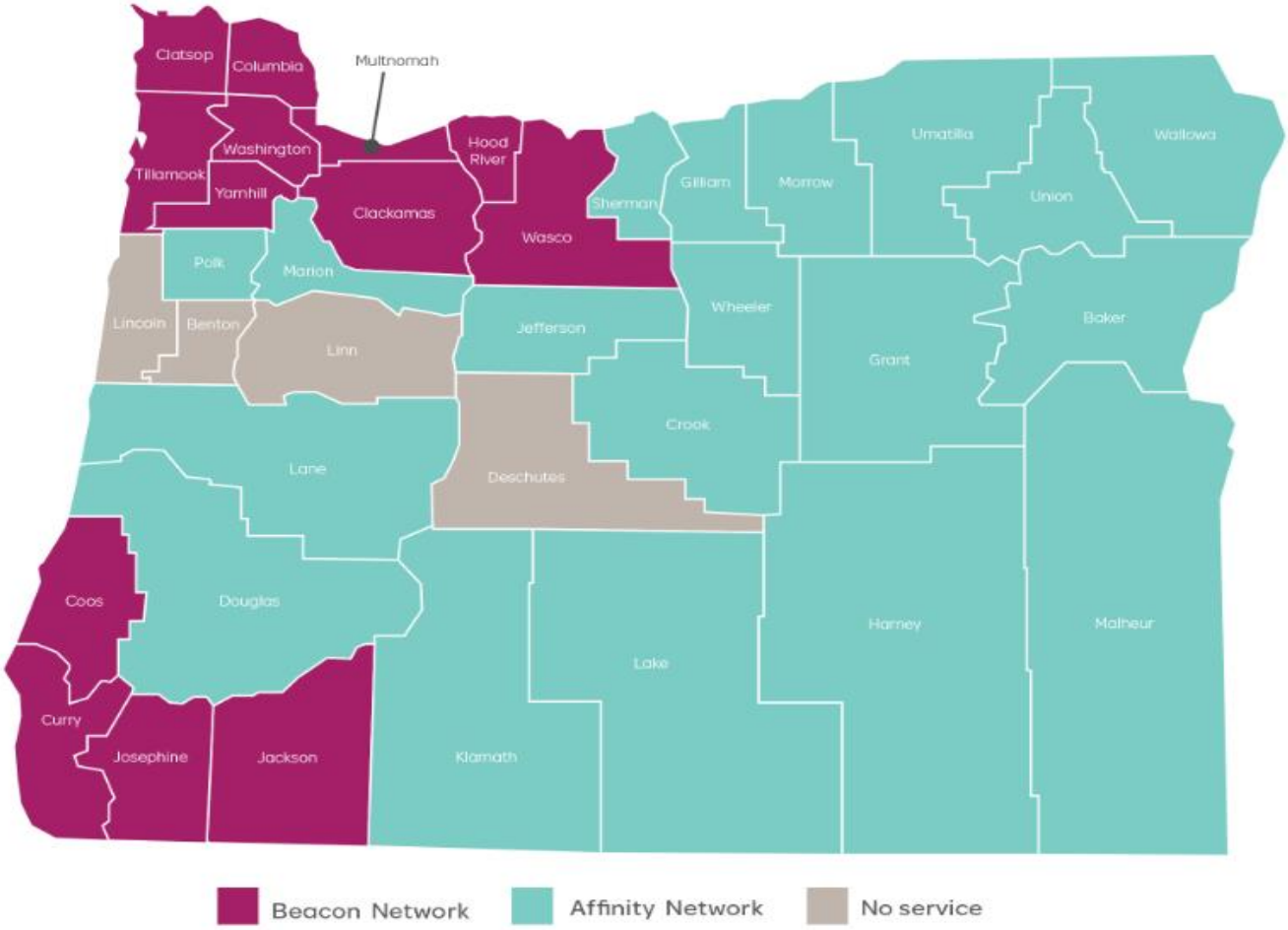
- Statewide network as of 2020
- No referrals required
- Small group Synergy members need to pick PCP
  - PEBB Synergy members will need to pick a “PCP 360”

OHSU and CCN networks

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

Individual Networks

Individual Network Service Area



Beacon Network

What is the Beacon Network?

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

Affinity Network

What is the Affinity Network?

- Clinically integrated network, which includes 14 health system partners and their referring providers
- PCP selection is required
- Available in Marion and Polk County in 2021
- Exiting Deschutes County in 2021
- Exclusive Provider Organization (EPO)

Commercial benefits

2021 Benefit changes

Commercial benefits
OEBB/PEBB Benefit changes

- Effective 10/1/2020 eviCore increases initial visits from 6 to 12 for PT/OT/ST
- Alternative care no longer requires authorization through eviCore
- No benefit changes for PEBB
- PEBB
- Viscous Supplementation benefits discontinued for 2021

Commercial benefits
Beacon/Affinity

- All Individual/exchange plans offered in 2021 will remain Exclusive Provider Organization (EPO) plans
  - EPO plans do not have out-of-network benefits
- Individual/exchange members must select a primary care physician (PCP)
- Members who do not select a PCP will automatically be assigned one based on where the member resides

Commercial benefits

Beacon/Affinity

- Enhanced Virtual Care Visits
- Choose Healthy (also includes small group)
  - Member discount for alternative care services through American Specialty Health (ASH)
- Individual Assistance Program (IAP)
  - Through Cascade Centers

Claims

Claims

New remittance design

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

Claims

Corrected claims

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

  P.O. Box 40384

  Portland, OR 97240

Claims

Clinical edits – Clinical Editing Systems

- Professional claims – professional clinical edits, Procedure to Procedure (PTP) edits, and Medically Unlikely Edits (MUE) edits
- National Correct Coding Initiative (NCCI) links
  - MUE information: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE
  - PTP coding edit information: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits
  - NCCI FAQ: cms.gov/medicare/national-correct-coding-initiative-edits/ncci-faqs

Claims

Multiple Therapy Reductions

- Multiple Therapy Fee Reduction applies to codes with multiple procedure indicator of “5”
- First unit of Therapy code is allowed at full fee schedule amount. Subsequent units/procedures subject to 20% discount
- Multiple therapy fee reduction rules apply to percent of charge or discount contracts
- Moda Health does not apply multiple procedure reductions to Osteopathic Manipulative Treatment (OMT) or Chiropractic Manipulative Treatment (CMT)
- modahealth.com/pdfs/reimburse/RPM022.pdf

Claims

Multiple Therapy Reductions – Example #1

CPT code	Units	Allowed Amt.	Discount	Reduced allowed
97110 (primary)	1	50.00	N/A	N/A
97035	1	40.00	20%	32.00
97140	1	40.00	20%	32.00

Claims

Multiple Therapy Reductions – Example #2

CPT code	Units	Allowed Amt.	Discount	Reduced allowed
97110 (primary)	3	150.00	20% (units 2 and 3)	130.00
97035	1	40.00	20%	32.00
97140	1	40.00	20%	32.00

Medicare Advantage updates

Medicare Advantage updates

2021 plan changes

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

Medicare Advantage updates
2021 plan changes

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

Moda Medicare Advantage Participation
=
Summit Health Medicare Advantage participation

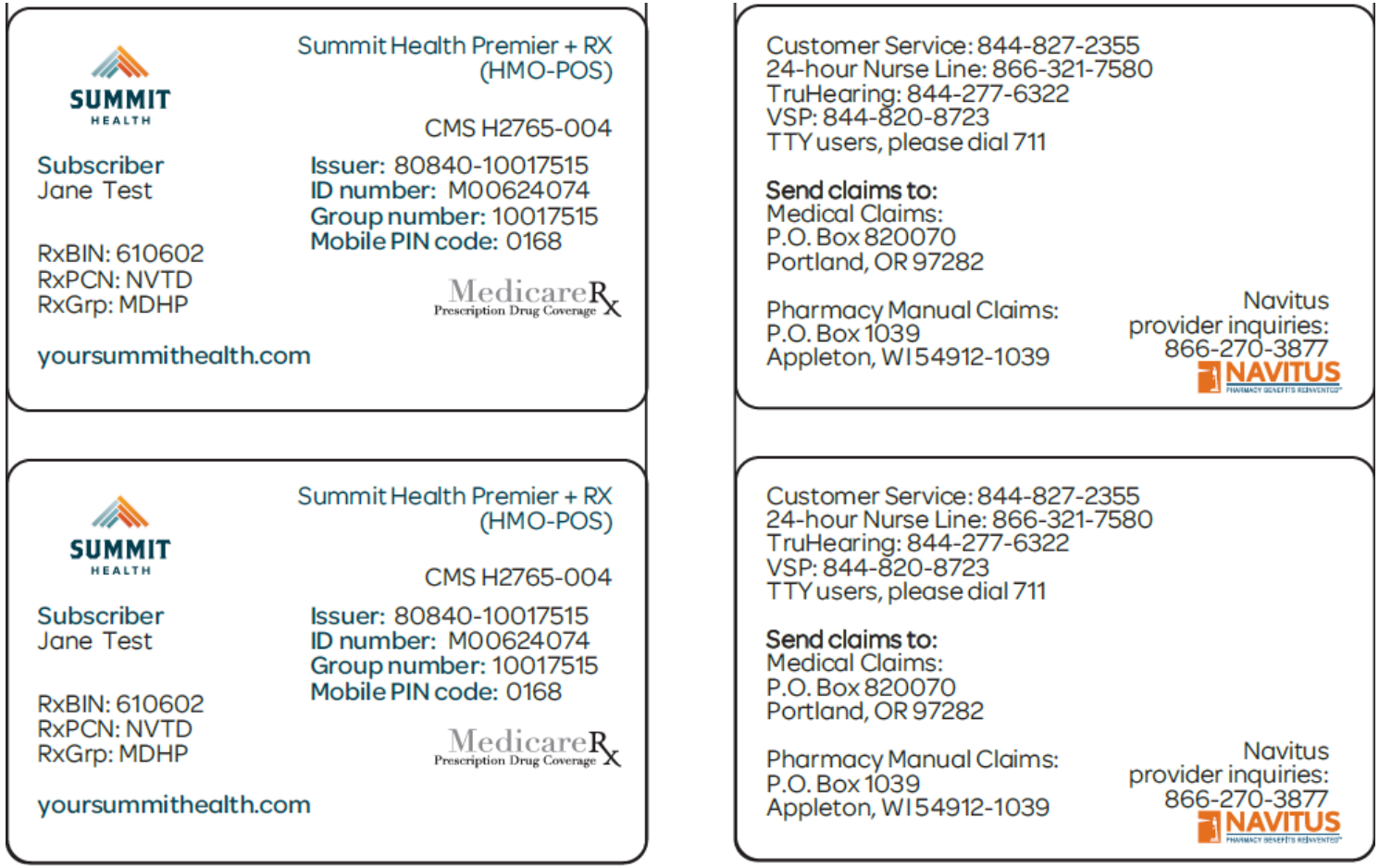
providerrelations@yoursummithealth.com

yoursummithealth.com

SUMMIT HEALTH

Medicare Advantage updates

Summit Health Plan Sample Card



Medicare Advantage updates

2021 Benefit changes

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

Medicare Advantage updates

Extra Care

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

Patient name:

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

Notes

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

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

Be better