# 2020 Provider Workshop

Presented by Moda Health

# Welcome

# Agenda

- Network updates
- Benefit Updates
- Claims/Billing
- Healthcare services
- Medicare updates

# Commercial networks

2021 Commercial networks

# 2021 Commercial Networks -Group

## Connexus

- Statewide PPO plan
- PCP selection, referrals not required

## Synergy

- Coordinated care plan for employer groups offered statewide

# 2021 Commercial Networks - Individual

## Beacon

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

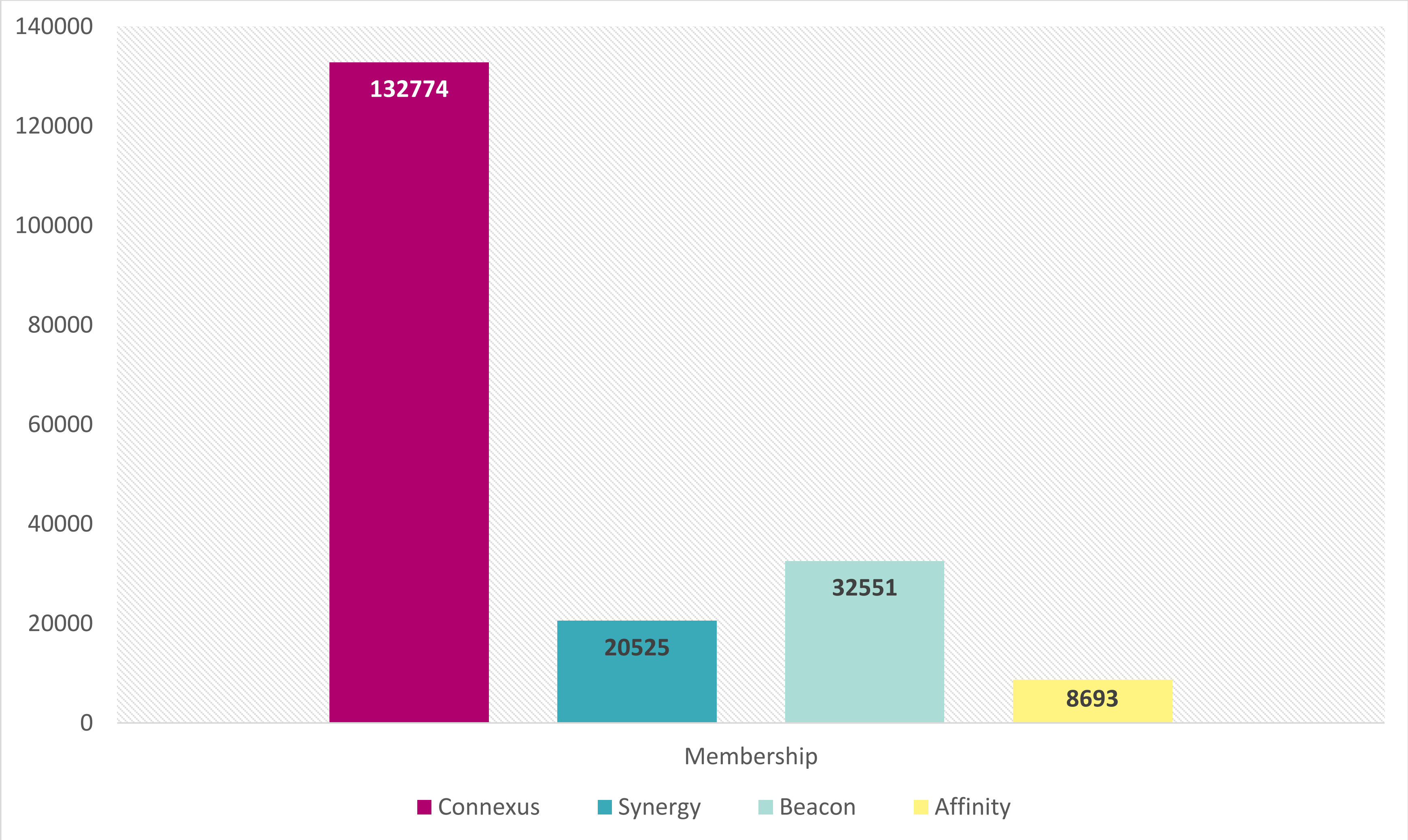
## Affinity

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

# 2021 Commercial Networks - Group

| Network | Description |
| --- | --- |
| OHSU PPO | • OHSU employee plan.<br>• Tiered benefits<br>• Provider participation determined by OHSU |
| OHSU EPO | • OHSU employee plan.<br>• Tiered benefits; <u>no out of network coverage</u>.<br>• Provider participation determined by OHSU. |
| OHSU Tuality Health & Assoc. | • Tuality Hospital employee plan.<br>• Provider participation determined by Tuality. |
| CCN | Tier 2 benefit plan for OHSU PPO and OHSU EPO |

# Commercial Membership - 2020



# Commercial PPO networks

# Connexus
## Small and Large Group plans

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

# OHSU and CCN networks

- OHSU PPO
  - Tier 1 benefit plan for OHSU employees only with statewide participation determined by OHSU (closed panel)
- OHSU EPO
  - Tier 1 benefit plan for OHSU employees in the Portland Metropolitan Area (closed panel)
- Community Care Network (CCN)
  - Tier 2 benefit plan for OHSU PPO and OHSU EPO only with participation determined by OHSU (closed panel)
- OHSU Tuality Health and Associates
  - Tuality employee plan (closed panel)

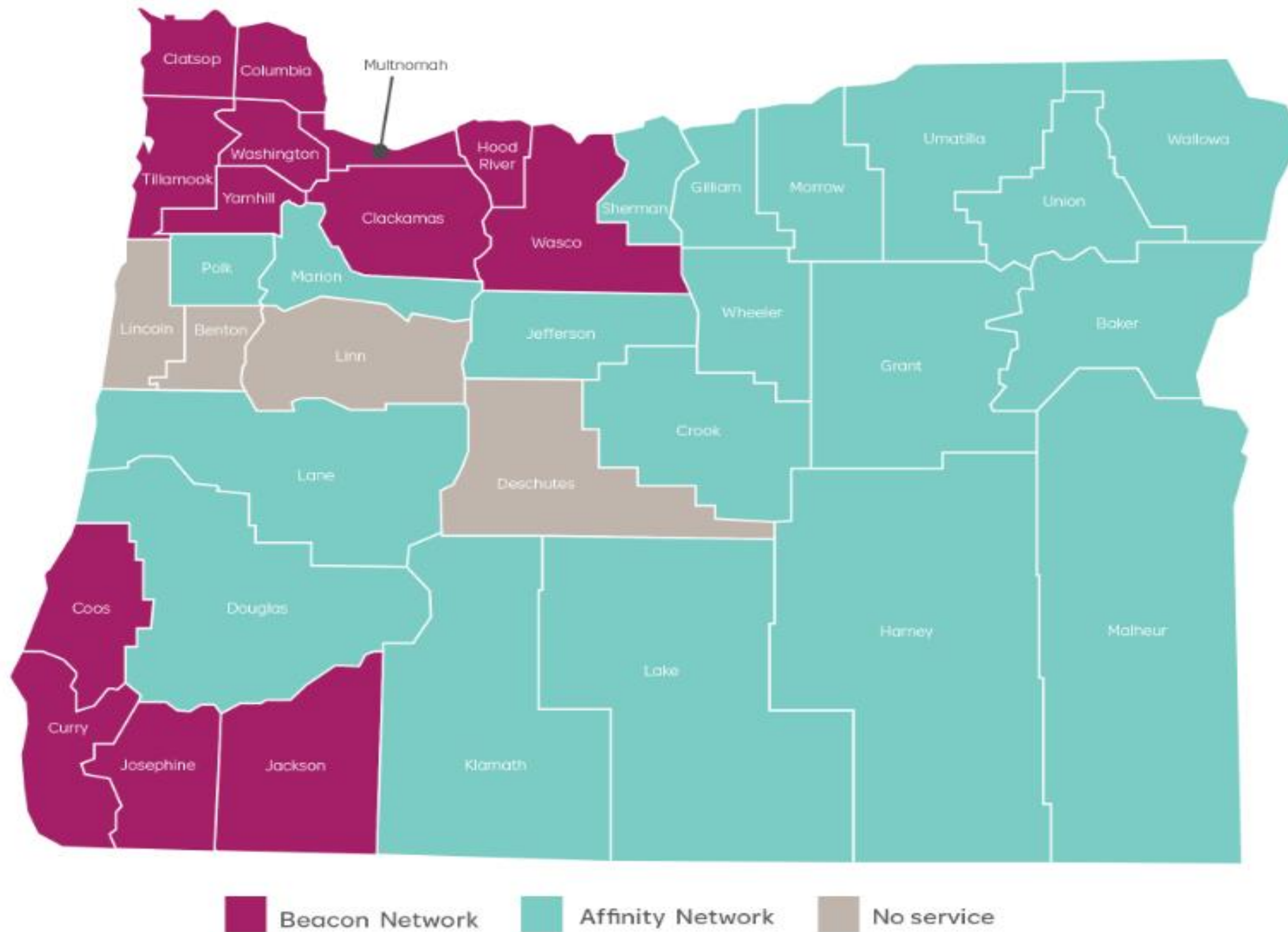
# Value-based Care Networks

# Synergy Network

- Statewide as of 2020
- No Referrals required
- No longer risk based as of Jan. 1, 2020
- Small group Synergy members need to pick PCP
  - PEBB Synergy members will need to pick a “PCP 360”

# Individual Networks

# Individual Network Service Area



# Beacon Network

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

# Affinity Network

What is the Affinity Network?

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

# Commercial benefits

2021 Benefit changes

# Commercial benefits
## OEBB/PEBB Benefit changes

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

# Commercial benefits
## OHSU

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

# Commercial benefits
## Beacon/Affinity

- Reduced copay for virtual care: $10 copay
- Out of area coverage for dependent students 18-26 years of age living out of state

# Claims/Billing

# Telehealth – Temporary COVID-19

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

# Claims

## Technical Component (TC)/Professional component(PC)

- PC/TC status indicator 1, 6, and 8 – Modifier 26 may be used
- PC/TC status indicator 1 – TC modifier may be used
- Not appropriate to unbundle TC and PC components and bill separately under the same Tax ID
- modahealth.com/pdfs/reimburse/RPM008.pdf

# 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 |

# Claims

## Modifiers 58, 78 & 79

- Valid for procedures with Global Days indicator of 010 or 090
- Modifier 58 – Documentation that the subsequent procedure was a staged or anticipated procedure of the original surgery may be included in the operative report for the original surgery or the preoperative documentation.
- Modifier 78 Fee adjustments- 70% of global allowance for that procedure (Medicare Advantage and Commercial)
  - Out of network Medicare Advantage - intra-operative portion of the global allowance
- Modifier 79 – submit documentation with claim or submit upon request
- modahealth.com/pdfs/reimburse/RPM010.pdf

# Claims
## Incident to Services

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

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

  modahealth.com/pdfs/reimburse/RPM040.pdf

# Claims

## Clinical edits – Clinical Editing Systems

- Professional claims – professional clinical edits, Procedure to Procedure (PTP) edits, and Medically Unlikely Edits (MUE) edits
  - Practitioner PTP edits apply to ASCs
- Facility claims – Outpatient hospital CCI, PTP, and MUE edits
- Claims exempt from Outpatient Prospective Payment System (OPPS) edits, status indicators and rules
  - Critical Access Hospitals (CAH) – Type of Bill 085x
  - Rural Health Clinic (RHC) – Type of Bill 071x
  - Federally Qualified Health Center (FQHC) – Type of Bill 077x
  - modahealth.com/pdfs/reimburse/RPM002.pdf

# Claims

## Clinical edits – Bilateral Procedures

Bilateral Procedure indicator of “1”

- One line, one unit, and modifier 50
    - Also applies to Ambulatory Surgery Centers (ASCs)
- Reimbursed at 150% of usual applicable fee schedule rate

Bilateral Procedure indicator of “3”

- One line, one unit, and modifier 50 or 2 lines with RT and LT modifiers
- Reimbursed at 200% of usual applicable fee schedule rate

Bilateral Procedure indicator of “0”, “2”, or “9”

- Modifier 50 is invalid for these procedure codes

# Claims

## Clinical Edits – Medically Unlikely Edits (MUE)

- MUE Adjudication Indicator (MAI) of “1” – appropriate modifiers may be used to report the same HCPCS/CPT code on separate lines.
- MAI of “2” – Absolute date of service limit that cannot be overridden or bypassed with a modifier
- MAI of “3” – Possible, but medically unlikely that that more units than the MUE value would be performed on the same date of service.
  - Edits applied during claims processing
  - Written appeal required for higher quantity consideration

modahealth.com/pdfs/reimburse/RPM056.pdf

# Claims

## Clinical Edits – Drug and Biologicals, Wastage and/or Discarded Amounts (Modifier JW)

Moda Health will reimburse for discarded or wasted amounts of drug only when all of the following requirements are met

- Drug is only supplied in single-use vials/packages
- Physician's orders must be clearly and completely documented
- Amount administered and discarded amount must be clearly and completely documented
- Amount administered and discarded must be billed on separate lines with JW appended to discarded amount

# Claims

## Clinical Edits – Drug and Biologicals, Wastage and/or Discarded Amounts (Modifier JW)

Wastage reimbursement only for the minimum amount of drug above what was actually ordered to arrive at the nearest whole vial using the vial size and dose that result in the least amount of wastage.

**Example**: Physician orders 180mg of Drug. Drug is manufactured in 100mg or 150mg single use vials. Physician uses two 100mg vials and is reimbursed for 20mg of wastage

**Example**: Physician orders 180mg of Drug. Drug is manufactured in 100mg or 150mg single use vials. Physician uses one 100mg vial and a 150mg vial. Physician is still only reimbursed for 20mg of wastage

# Claims

## Clinical Edits – 340B discount program

- Drugs and biologicals purchased through the 340B Drug Pricing Program must be billed using modifier, JG or TB.
- Reimbursement is 22.5% less than Average Sales Price (ASP)
- Discarded drug amounts should be billed on a separate line with the JW modifier and the appropriate 340B modifier

modahealth.com/pdfs/reimburse/RPM063.pdf

cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf

# Claims

## Clinical Edits – Medicare Advantage LCD/NCD Edits

- CMS documents a wealth of very specific coding and coverage requirements
- National Coverage Determinations (NCDs),
- Local Coverage Determinations(LCDs, e.g. Noridian LCDs), transmittals, MLN articles, and other sources
- Example: Why am I getting denials of CPT code 85025?
  - Claims for CPT code 85025 will deny for not meeting medical necessity criteria when not billed with approved diagnosis code from NCD 190.15 Blood Counts.

modahealth.com/pdfs/LCD_NCD_edit_FAQ.pdf

# Claims

## National Correct Coding Initiative (NCCI) links

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

# 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

## 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

# Benefit Tracker

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

# Healthcare Services

# Referrals

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

# Healthcare Services
## eviCore

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

  modahealth.com/medical/utilizationmanagement.shtml

# Healthcare Services

## eviCore

- Check Benefit Tracker to determine if the 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<br>○ Not My Moda Medical Home<br>○ In-Network<br>○ Out of Network<br>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<br>• Toll Free: 1-800-258-2037<br>• Fax: 503-243-5105<br>Plan has eviCore for the following services: Advanced Imaging, Cardiology, Spine/Joint, Pain Management, PT/OT/SPT, Chiropractic and Acupuncture.<br>Evicore - Authorizations<br>• Phone Number: (844) 303-8451<br>• Website: www.evicore.com |

# Healthcare Services
## Magellan Rx

- Provider-administered injectable drug program
  - Prior authorization required for specific injectable specialty medications
  - modahealth.com/medical/injectables/
- Site of Care program
  - Certain provider-administered drugs only authorized in outpatient setting or patients home
  - modahealth.com/medical/siteofcare.shtml
- Claim edits program

# Healthcare Services

## Infused specialty medications

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

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

# Appeals

# 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

# 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.

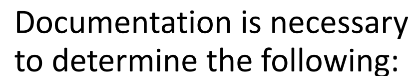
- A provider may file a pre-service member appeal on behalf of a member in writing
- The commercial or marketplace member must complete a Moda Health Protected Health Information form

# Appeals

## Medical record requests

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

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



Documentation is necessary to determine the following:

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

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

# Medicare Advantage updates

# Medicare Advantage updates

## 2021 plan changes

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

# Medicare Advantage updates
## 2021 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

# Medicare Advantage updates

## Summit Health Plan Sample Card

Summit Health Premier + RX
(HMO-POS)

CMS H2765-004

Subscriber
Jane Test

Issuer: 80840-10017515
ID number: M00624074
Group number: 10017515
Mobile PIN code: 0168

RxBIN: 610602
RxPCN: NVTD
RxGrp: MDHP

MedicareRx
Prescription Drug Coverage

yoursummithealth.com

Customer Service: 844-827-2355
24-hour Nurse Line: 866-321-7580
TruHearing: 844-277-6322
VSP: 844-820-8723
TTY users, please dial 711

**Send claims to:**
Medical Claims:
P.O. Box 820070
Portland, OR 97282

Pharmacy Manual Claims:
P.O. Box 1039
Appleton, WI 54912-1039

Navitus
provider inquiries:
866-270-3877

Summit Health Premier + RX
(HMO-POS)

CMS H2765-004

Subscriber
Jane Test

Issuer: 80840-10017515
ID number: M00624074
Group number: 10017515
Mobile PIN code: 0168

RxBIN: 610602
RxPCN: NVTD
RxGrp: MDHP

MedicareRx
Prescription Drug Coverage

yoursummithealth.com

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Appleton, WI 54912-1039

Navitus
provider inquiries:
866-270-3877

# Medicare Advantage updates
## 2021 Benefit changes

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

# Medicare Advantage updates
## Supplemental benefits

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

# Medicare Advantage updates

## Extra Care

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

Patient name:

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

Notes

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

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

# Medicare Advantage updates

## Organization Determinations

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

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

# Medicare Advantage updates

## Plan Directed Care

- Ensures Medicare Advantage plan members receive medically necessary services that are covered by their Moda Health Medicare Advantage health plan

- **Referrals to non-participating providers** – Participating providers referring Medicare Advantage members to non-participating physicians, providers or agencies must obtain prior authorization for certain procedures and services as outlined in the Moda Health Medicare Advantage agreement

# Medicare Advantage updates

## Compliance attestation

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

# Medicare Advantage updates
## Provider directory outreach

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

Be better