Oscar Health Texas Provider Manual Supplement

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This State Specific Supplement is intended to be read alongside the Oscar Health Provider Manual (available at provider.hioscar.com/resources).

Introduction

Overview

Welcome to Oscar. This document is intended to serve as an addendum to the Oscar Health Provider Manual. The following are Texas specific requirements.

Our Service Areas

Oscar's Service Area is comprised of the following counties in Texas: Hays, Travis, Williamson, Bastrop, Caldwell, El Paso, Collin, Dallas, Denton, Rockwall, Tarrant, Ellis, Parker, Fort Bend, Galveston, Harris, Montgomery, Brazoria, Bexar, Comal, Atascosa, and Guadalupe.

Our Network

Our Delegated Vendors

In addition to the national vendors listed in the corresponding section of the Provider Manual, Oscar utilizes the vendors below in Texas:

Service	Partner	Contact Information
Delegated Prior Authorization *Please refer to the "Delegation and Oversight" section for Utilization Review service categories delegated to each partner.*	eviCore	Utilization Management: For case initiation, please access the Portal (www.eviCore.com) or contact eviCore via phone 855-252-1118 Additional resources available at https://www.evicore.com/healthplan/Oscar
	American Specialty Health (ASH)	Utilization Management: Provider Portal: www.ASHLink.com Fax: 877-248-2746 Mailing Address: American Specialty Health (ASH) P.O. Box 509077, San Diego, CA 92150-9077

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Delegated Utilization Management *Please refer to the "Delegation and Oversight" section for Utilization Review service categories delegated to each partner.*	ProgenyHealth *(Effective 4/1/22)*	*Effective April 1, 2022:* Utilization Management: For Neonatal Intensive Care Unit (NICU) and special care nursery (SCN) admission notifications, please contact ProgenyHealth directly via secure fax (sFax): 1-888-832-2006 Additional resources available at: www.ProgenyHealth.com
Pediatric Vision	Davis Vision	Claims Submission Address: Vision Care Processing P.O. Box 1525 Latham, NY 12110

Claims and Payment

Texas Gold Card

Oscar evaluates prior authorizations of Texas providers every six months to determine whether a provider has met certain qualification criteria under Texas law for an exemption from some or all prior authorization requirements for services on our prior authorization list as described in the Utilization Management section of the Oscar Health Provider Manual. Evaluation periods run from January to June and again from July to December of each year.

Eligibility: Provider prior authorization request data is screened by Oscar for each evaluation period. You do not need to request participation in the program. Oscar will perform reviews of prior authorization request data automatically. To be eligible for consideration for the exemption, Texas providers must have submitted at least five prior authorization requests under a single NPI for the same CPT code or service category, as determined by Oscar, during the most recent six-month evaluation period.

Qualification: If an eligible provider's prior authorization requests for a particular service during an evaluation period are approved at a 90% or greater approval rate, Oscar will exempt the provider, by NPI, from prior authorizations for that service.

Notice: Providers who meet the eligibility criteria for consideration for the exemption will receive a notification after the evaluation period about whether or not they have received a prior authorization exemption and, if the exemption is granted, to which services the exemption will apply. If you have received an exemption for some services and a denial of the exemption for other services, or you did not have five requests for a particular service, your eligibility for an exemption for those services will be re-reviewed on a biannual basis during subsequent evaluation periods. If you have received a denial for an exemption, you may appeal the decision pursuant to Oscar's internal complaints and grievances procedure as described in the Grievance and Appeals processes listed in the Oscar Health Provider Manual.

Process: If you qualify for an exemption, Oscar's standard claims processes apply and your exemption will be taken into account. Further, exemption sharing is generally prohibited except that certain rendering providers (such as a physician assistant or nurse practitioner under a physician's supervision) may use a treating provider's exemption if the rendering provider is providing the service under the orders of that treating provider. The claims process for the rendering provider does not change.

Rescission: Once the exemption is granted, it may be rescinded after a subsequent evaluation period based on criteria determined by Texas law. Your exemption will remain in effect for at least six months. If your exemption is rescinded, you may request a review of the exemption by an independent review organization. Oscar will notify TDI of your request.

Timely Filing of Claims

In addition to the Timely Filing requirements listed in the Oscar Health Provider Manual, providers are expected to adhere to the state-specific deadlines outlined below:

In-Network Providers

In-network providers should refer to their respective contracts for timely filing deadlines when submitting claims. Unless a different timely filing deadline is specified in the contract, the timely filing deadline for an in-network provider to submit claims will be **180 calendar days** from the last day of service.

Out-of-Network Providers

Out-of-network providers in Texas shall submit all claims **within 95 days** from the last date of service, unless the state where such services were provided mandates a different timely filing deadline, which shall control.

Requests for Additional Information

In addition to all guidelines regarding Requests for Additional Information outlined in the Oscar Health Provider Manual, providers are expected to adhere to the state-specific requirements regarding Itemized Bill Content as listed below:

Itemized Bill Content

Unless a different timeline is specified in the contract, providers must submit the requested information to Oscar, along with the associated Explanation of Payment (EOP) and/or a copy of the information request letter, within **90 calendar days** of receipt of the initial request. All requested documentation must be sent to:

Via Mail
Oscar Insurance Company
PO Box 52146
Phoenix AZ, 85072–2146

Via Fax
(888) 977-2062

If the requested documentation received from the provider is insufficient or incomplete, Oscar will send additional requests to the provider detailing what information is still outstanding. All requests (including subsequent requests made per incomplete documentation) must be fulfilled **within 90 calendar days** from the initial request. Oscar will not be liable for claim payment or interest unless and until the documentation request has been properly satisfied, at which time the applicable timeframe for processing the claim will commence.

Timely Processing of Claims

Oscar and its delegated provider organizations and hospitals are required to meet the claims timeliness standards established by state law. Oscar will abide by the guidelines of the Texas Department of Insurance (TDI), which stipulate that all undisputed claims requiring no additional information must be processed and paid or denied within **30 calendar days** for claims submit electronically and **45 calendar days** for claims submitted by mail, unless otherwise set forth by the provider contract.

Please consult the corresponding section in the Oscar Health Provider Manual for details on how to enroll in ACH & ERA.

Claim Corrections and Late Charges

In addition to the guidelines around Claims Corrections and Late Charges listed in the Oscar Health Provider Manual, providers should be aware of the state-specific processes and time frames listed below:

Providers who believe they have submitted an incorrect or incomplete claim may submit an updated claim within **180 calendar days** of the last date of service (the same timely filing limit

established in the “Timely Filing of Claims” section above). Providers must submit a corrected claim when previously submitted claim information has changed (e.g. procedure codes, diagnosis codes, dates of service, etc.).

Reimbursement Requirements and Policies

Interest Payments

If Oscar does not pay a clean claim within the state-mandated time frame indicated above, Oscar and its delegated provider organizations will pay a late payment penalty in accordance with Texas Department of Insurance (TDI) regulations, unless otherwise specified in the provider contract.

Similarly, if Oscar processes and pays a portion, but not all, of the appropriate contracted rates on a clean claim, Oscar and its delegated provider organizations will pay an underpayment penalty in accordance with TDI regulations. The penalty will be calculated based on the specific claim lines that were underpaid.

Interest on Late Payments

Oscar and its delegated provider organizations will pay the following payment schedules unless otherwise specified in the provider contract:

Penalty Type	Payment Owed
Late claims: days 1-45 after deadline to pay*	Lesser of one hundred thousand dollars ($100,000) OR fifty percent (50%) of the difference between charges and negotiated rate
Late claims: days 46-90 after deadline to pay*	Lesser of two hundred thousand dollars ($200,000) OR one hundred percent (100%) of the difference between charges and negotiated rate
Late claims: days 91+ after deadline to pay*	Lesser of two hundred thousand dollars ($200,000) OR one hundred percent (100%) of the difference between charges and negotiated rate plus eighteen percent (18%) interest per annum

These payments are issued to the provider (excluding copayments, coinsurance amounts, and deductibles) on claims for which the original payment is not mailed before Oscar’s state-mandated timely payment deadline. This deadline is:

- **30 calendar days** after the earliest date the undisputed claim is received for claims submitted electronically
- **45 calendar days** after the earliest date the undisputed claim is received for claims submitted by mail

If a claim is pended with a request for additional information, the timely payment deadline will be calculated from the date when all requested additional information was received.

Interest on Underpayments
If Oscar processes a clean claim incorrectly and adjusts the claim, interest on the adjusted payment amount (excluding copayments, coinsurance amounts, and deductibles) is due from the original date the claim payment was due. The underpayment penalties stipulated by TDI are outlined in the table below:

Penalty Type	Payment Owed
Underpaid claims: days 1-45 after deadline to pay*	Lesser of one hundred thousand dollars ($100,000) OR fifty percent (50%) of the underpayment amount
Underpaid claims: days 46-90 after deadline to pay*	Lesser of two hundred thousand dollars ($200,000) OR one hundred percent (100%) of the underpayment amount
Underpaid claims: days 91+ after deadline to pay*	Lesser of two hundred thousand dollars ($200,000) OR one hundred percent (100%) of the underpayment amount plus eighteen percent (18%) interest per annum on the underpayment amount

*In institutional cases, 50% of the penalty is due to the provider and 50% is due to TDI
*Calculated for each day past the timely payment deadline from either the original date received for clean claims or the date requested additional information was received for denied claims.

Claims Overpayment
Should Oscar determine that it has overpaid a claim, Oscar will submit a written refund request to the provider. Oscar must make any refund requests within **180 calendar days** of the date of payment of the affected claim, except in the case of fraud or a material misrepresentation by a physician or a provider.

Additional guidelines regarding Claims Overpayment can be found in the Oscar Health Provider Manual.

Utilization Management

Program Staff
Please consult the Oscar Health Provider Manual for additional details regarding Oscar's UM Program Staff authority. Listed below are state-specific staff authority guidelines.

	Participation in UM program	Authority to issue Adverse Determination?
Licensed Pharmacists	Review and approve UM pharmaceutical requests based on Oscar documents, policies, procedures, and established Clinical Criteria; deny initial requests and escalate non-approval appeals for physician review; communicate with providers.	No

Post-Stabilization

Oscar **requires** authorization as a prerequisite for payment for inpatient medical care following stabilization of an emergency medical condition. Non-participating facilities are required to notify the plan once our member is stabilized and prior to any admission or post-stabilization care. Unless otherwise specified in their contracts, Oscar participating facilities are required to notify the plan within 24 hours or by the end of the first business day following admission. The plan will review these requests for medical necessity, level of care, appropriateness of care, and benefit determination.

Oscar Participating Facilities: Notification may be communicated to Oscar's Clinical Review Team via phone (1-855-OSCAR-55) or fax (1-844-965-9053).

Non-Participating Facilities: Notification must be communicated to Oscar's Clinical Review Team via a dedicated phone line: 1-844-804-6918.

Delegation and Oversight

Please consult the Oscar Health Provider Manual for additional details regarding Oscar's national vendors delegated for UR. Listed below are state-specific vendors delegated for UR.

Delegate	Service Categories Delegated for UR
eviCore	Medical: specialty outpatient services ● Cardiac imaging ● Genetic testing ● Medical and radiation oncology ● Musculoskeletal management (including chiropractic treatment and injections for pain management) ● Radiology ● Sleep therapy and diagnostics ● Joint and spine surgery
American Specialty Health (ASH)	Outpatient Physical and Occupational Therapy
ProgenyHealth *(Effective 4/1/22)*	UM and Case Management (CM) services from date of NICU and SCN admissions through discharge, continuing through the first year of life (365 days after birth) ● NICU and SCN admissions after birth ● All readmissions – elective and emergent – for the first year of life (365 days after birth) for all members previously managed by ProgenyHealth
Davis Vision	Pediatric vision

Peer to Peer Process

Please consult the Oscar Health Provider Manual for additional details regarding peer to peer processes. Listed below are state-specific pre-denial peer to peer procedures:
Providers are notified of the opportunity to discuss a medical necessity denial with an Oscar UM physician prior to the determination being issued. If the provider of record does not accept a pre-denial peer-to-peer, they are notified of the opportunity again in the denial letter.

Grievances and Appeals

Grievances

In addition to the Grievance and Appeals processes listed in the Oscar Health Provider Manual, please note the state-specific time frames outlined below:

Members may submit grievances via mail, fax, or email for up to **180 calendar days** following any incident or action that is the subject of the member's dissatisfaction using Oscar's Grievance Form, which can be found at www.hioscar.com/forms.

Oscar will respond to grievances within **thirty (30) calendar days** of receipt.

Access to Care

Availability Standards

Please refer to the Oscar Health Provider Manual for additional information on Oscar's availability standards across our networks. Oscar adheres to the availability standards listed below in Texas:

Activity	Standard
Regular and routine appointments for primary car services, high volume specialty care, high impact specialty care	3 weeks
Urgent care appointments	24 hours
Care for non-life-threatening behavioral health emergency	6 hours of request
Urgent behavioral health appointment	48 hours of request
Preventive care services for a child	Within two months, or earlier if necessary, for specific preventive care services
Preventive care services for an adult	Within three months [3]
Initial visit for routine behavioral health appointment	10 business days of request
Follow up routine behavioral health appointment	15 business days of request
Emergency Care	Immediate access to the nearest receivi ng center based on prudent layperson a nd reasonable person definitions. No prior authorization required.