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 https://www.hioscar.com/for-providers/resources).

Introduction

Overview

Welcome to Oscar. This document contains the Texas state-specific requirements and is intended to serve as an addendum to the Provider Manual.

Claims and Payment

Texas Preauthorization Exemption (Gold Card)

In accordance with Texas Insurance Code § 4201.653 and § 4201.655 and 28 TAC 19.1731(b), Oscar evaluates prior authorizations of Texas providers annually to determine whether a provider has met certain criteria under Texas law for a prior authorization exemption. Prior authorization requirements for services on our prior authorization list are described in the Utilization Management section of the Oscar Health Provider Manual.

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 one-year 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 an annual 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 one (1) year. 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 specified in the Provider Manual, providers are expected to adhere to Texas state-specific deadlines. In-Network Providers should refer to their respective contracts for timely filing deadlines when submitting claims. Out-of-Network Providers shall submit all claims within 95 days of the last date of service.

Referrals

Overview

HMO plans in Texas require that Primary Care Providers (PCPs) submit electronic referrals via Oscar's Provider Portal https://www.hioscar.com/for-providers/resources for specialty care. Reference the provider directory and member plan details on which plans require referrals. The below section details the referral requirements.

Referral Requirements

Referrals are required for care provided by specialists, with some key exceptions

Referral exceptions include providers practicing in the following specialties: OBGYN, emergency care, urgent care, behavioral health. There may be additional situations where a referral is not required, as specified by applicable law or regulation. Please refer to the Referral Requirement Exclusions List https://www.hioscar.com/asset/referral-exclusions-list on Oscar's website for the most current referral policies, requirements and exceptions.

Referrals must be submitted via the Oscar Portal

All referrals must be submitted electronically for review via the Oscar Provider Portal. Referrals submitted through the portal with all necessary information will be reviewed in real-time. Paper referrals or referrals submitted through alternative channels may not be considered valid. If you have any difficulty submitting a referral via the portal, contact Provider Services at (855) 672-2755(Option 4).

Only a member's assigned PCP or PCP within the same TIN can submit a referral
Referrals must be submitted by the member's PCP or by a PCP billing with the same tax identification number (TIN) prior to a member receiving specialist services, subject to the aforementioned exceptions. Referrals submitted by any other network PCP will be considered pending until the member requests assignment to the submitting PCP. Members may make PCP selections in their digital account or by calling Oscar's Member Services department at (855) 672-2755 (Option 2). In cases where a member reports being unable to access their PCP in a timely manner, Oscar may take steps to provide the member with access to a referral. In such cases, the member will remain assigned to their original PCP, unless the member requests a PCP change.

Specialists cannot submit referrals unless they are authorized as a PCP (see section below). If a network specialist sees a need for a member to go to another specialist, the specialist must coordinate with the member's PCP to issue an additional referral.

Referrals are effective for the designated time period and number of visits determined by the PCP, until otherwise expired
Referrals become effective immediately once validated and will be visible on the member's profile page in the provider portal. The PCP determines the number of visits and the duration of each referral, up to a maximum of 365 calendar days. Referrals can start up to 30 days prior to the referral submission date. Any unused visits become invalid after the end date. If additional care is needed after a referral expires, the member or specialist must contact the member's PCP to request a new referral.

Referrals will be valid at the specialty level
When issuing a referral, a PCP can recommend a specific in-network specialist, but the referral will be valid for all specialists within the network who practices in that specialty.

Referrals will not carry over from a previous plan
Referrals from a member's previous health plan will not carry over to their Oscar plan. PCPs will be required to submit a new referral to Oscar to ensure members have a valid referral during the plan year.

Specialists must confirm there is a valid and active referral before providing care
Specialists are responsible for confirming members have a valid and active referral for their specialty prior to providing care. Referrals must be submitted by a member's PCP. Specialists can confirm the status of a referral by checking the member's profile page in the Oscar provider portal or by contacting Provider Services at (855) 672-2755 (Option 4). Paper referrals will not be considered valid, and will require that the PCP submits a referral directly to Oscar.

Members cannot be held financially responsible for claims denied due to lack of referral
If a specialist, practicing in a specialty that requires referral, renders services without a valid referral on file, the claim will not be covered and the member cannot be held financially responsible for claims denied due to lack of referral. Reference the Balance Billing section of the Provider Manual for additional information.

Referrals do not waive existing prior authorization requirements
The referral requirements (listed within this section) are in addition to notification and/or prior authorization requirements.

Referrals requirements apply to all members within an applicable plan
For Oscar plans that require a referral, those referral requirements apply to the policyholder and any dependents on their plan. Referrals for one member on a plan do not apply for others on the plan unless separately submitted.

No administrative fees can be applied for issuing a referral
Providers may not charge administrative fees to members for issuing referrals.

Referrals apply to planned outpatient procedures
Members without a valid referral on file for the servicing provider of a planned outpatient procedure will not have coverage for the servicing provider's claim nor the facility claim. The servicing provider referral requirement (listed within this section) is in addition to prior authorization requirements.

Specialists can only act within the capacity of a PCP upon Oscar's review and approval. If a specialist is approved to act as a PCP for a specific member, that specialist will be expected to carry out all PCP responsibilities, including issuing referrals.
In applicable HMO plans, members are required to choose a PCP who meets the criteria outlined in the PCP section of the Provider Manual. However, Oscar may allow a specialist to serve as a PCP for members with chronic, disabling, or life-threatening conditions that require specialized care. In these cases, the specialist must agree to take on the responsibilities of a PCP, including providing and coordinating all primary and specialty care, and submitting referrals for additional specialty services. For more details on referral submission, refer to the relevant section above.

If a member wants an in-network specialist to be their PCP, they must contact Oscar's Member Services Department at (855) 672-2755 (Option 2). The initial request must come from the member, not the specialist. The requesting member will be provided with a form to make a formal request to allow a specialist to act as their PCP. Both the member and the specialist will need to complete and submit a request form to Oscar for this exception to be considered.

Once the request is submitted, it will be reviewed, and subsequent approval or denial will be communicated back to the member and/or Provider. Until the specialist is approved as the PCP, a referral is required for coverage of all services provided by that specialist, unless a referral exception applies. If the request for a specialist to act as a member's PCP is approved, referrals will no longer be needed for services with the specialist PCP, but will still be required for other specialists. For more information on which specialty services require a referral, please reference the Referral Requirements section above.