Oscar Health Oklahoma 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 Oklahoma specific requirements.

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 Oklahoma:

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
Delegated Utilization Management *Please refer to the "Delegation and Oversight"*	ProgenyHealth	*Effective April 1, 2022:* Utilization Management:

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section for Utilization Review service categories delegated to each partner.		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

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 Oklahoma shall submit all claims within **180 calendar 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 the initial request. All requested documentation must be sent to:

Via Mail
Oscar Health, Inc.
P.O. Box 52146
Phoenix, AZ 85072-2146

Via Fax
1-888-977-2062

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 Oklahoma Department of Insurance, which stipulate that all undisputed claims requiring no additional information must be processed and paid or denied within **30 calendar days**, unless otherwise set forth in the provider contract.

Claim Corrections and Late Charges

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

Interest on Late Payments: Oscar and its delegated provider organizations will pay interest at a rate of **ten percent (10%) per annum**, unless otherwise specified in the provider contract, of the payment 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. Please see the "Timely Processing of Claims" section for the applicable deadlines.

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 is 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.

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 **two years (730 calendar days)** of the date of payment of the affected claim except if the payment was made because of fraud committed by the claimant or health care provider, or if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim, or to satisfy the intent of OK ADC 365:10-11-11.

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.

Staff	Participation in UM program	Authority to issue Adverse Determination?
Licensed Pharmacists	Review and approve UM pharmaceutical requests	Initials - Yes

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	based on Oscar documents, policies, procedures, and established Clinical Criteria; deny initial requests and escalate non-approval appeals for physician review; communicate with providers.	Appeals - No

Delegation and Oversight

Please consult the Oscar Health Provider Manual for additional details regarding Oscar's national vendors delegated for Utilization Review (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	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

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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 complaints 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

Overview

Please consult the Oscar Health Provider Manual for additional details on how members access care within our networks. Additional information on plans available in this state can be found below:

If members subject to a PPO plan elect to see an out-of-network provider when the services could have been provided by an in-network provider, benefits will be available at a higher cost to them. Their coverage for medically necessary out-of-network services will be limited to the out-of-network rate and out-of-network cost sharing amounts, as shown on the member's Schedule of Benefits. In some cases, members may be required to meet certain prior authorization requirements to obtain coverage for medically necessary out-of-network services. Moreover, members may also be responsible for the difference between the out-of-network provider's charges and the amount allowed by Oscar, in addition to any applicable copayment, coinsurance and deductible.

Out-of-network benefits are available only when members receive services within the plan's service area. Except for certain limited circumstances such as emergency medical services or prior authorized care, they are responsible for paying the cost of all care that is provided by out-of-network, out-of-area Providers.