

# **Oscar Health**

# **Missouri Provider**

# **Manual**

# **Supplement**

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## Introduction

### Overview

Welcome to Oscar. This document is intended to serve as an addendum to the Oscar Health Provider Manual. The following are Missouri 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 Missouri:

Service	Partner	Contact Information
<b>Delegated Prior Authorization</b> <i>Please refer to the "Delegation and Oversight" section for Utilization Review service categories delegated to each partner.</i>	eviCore	<u>Utilization Management:</u> For case initiation, please access the Portal ( <a href="http://www.eviCore.com">www.eviCore.com</a> ) or contact eviCore via phone 855-252-1118  Additional resources available at <a href="https://www.evicore.com/healthplan/Oscar">https://www.evicore.com/healthplan/Oscar</a>
	American Specialty Health (ASH)	<u>Utilization Management:</u>  Provider Portal: <a href="http://www.ASHLink.com">www.ASHLink.com</a>  Fax: 877-248-2746  Mailing Address: American Specialty Health (ASH) P.O. Box 509077, San Diego, CA 92150-9077
<b>Delegated Utilization Management</b> <i>Please refer to the "Delegation and Oversight" section for Utilization Review</i>	ProgenyHealth	<u>Utilization Management:</u>  For Neonatal Intensive Care Unit (NICU) and special care nursery (SCN) admission notifications, please contact

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<i>service categories delegated to each partner.</i>		ProgenyHealth directly via secure fax (sFax): 1-888-832-2006  Additional resources available at: <a href="http://www.ProgenyHealth.com">www.ProgenyHealth.com</a>
<b>Pediatric Vision</b>	Davis Vision	<u>Claims Submission Address:</u> 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 **6 months** from the last day of service.

#### Out-of-Network Providers

Out-of-network providers in Missouri shall submit all claims **within 12 months** 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:

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***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 Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP), which stipulate that all undisputed claims requiring no additional information must be processed and paid or denied within **30 processing 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 **6 months for in-network providers or 12 months for out-of-network-providers** 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 **1% per month in addition to a penalty of 1% of the outstanding amount on the claim per day starting from 45 processing days after receipt of claim**, 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

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is not mailed before Oscar's state-mandated timely payment deadline. Please see the "Timely Processing of Claims" section for the applicable deadlines.

**Interest on Underpayments:** If Oscar processes a clean claim incorrectly and adjusts the clean 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 **12 months** of the date of payment of the affected claim. However, such time limit shall not apply where state law explicitly permits, including but not limited to, certain instances relating to suspected or actual fraud, waste, or abuse. In such instances of fraud or misrepresentation, Oscar must make any refund request or pursue offset within **five years** from the date of discovery.

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 based on Oscar documents, policies, procedures, and established Clinical Criteria; deny initial requests and escalate non-approval appeals for physician review; communicate with providers.	Initials – Yes Appeals - 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. If we do not respond within 60 minutes, the initial post-stabilization service is deemed approved. Unless otherwise specified in their contracts, Oscar participating facilities are

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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 Utilization Review (UR). Listed below are state-specific vendors delegated for UR:

Delegate	Service Categories Delegated for UR
eviCore	Medical: specialty outpatient services <ul style="list-style-type: none"> <li>• Cardiac imaging</li> <li>• Genetic testing</li> <li>• Medical and radiation oncology</li> <li>• Musculoskeletal management (including chiropractic treatment and injections for pain management)</li> <li>• Radiology</li> <li>• Sleep therapy and diagnostics</li> <li>• Joint and spine surgery</li> </ul>
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) <ul style="list-style-type: none"> <li>• NICU and SCN admissions after birth</li> <li>• All readmissions – elective and emergent – for the first year of life (365 days after birth) for all members previously managed by ProgenyHealth</li> </ul>
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](http://www.hioscar.com/forms).

Oscar will respond to grievances within **twenty (20) calendar days** of receipt. In some cases, Oscar may utilize an additional **14 day extension period** when needed. Oscar will notify the member of the extension via letter when applicable.