Oscar Health Michigan 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 Michigan 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 Michigan:

Service	Partner	Contact Information
Delegated Prior Authorization *Please refer to the "Delegation and Oversight" section for Utilization Review service categories delegated to each partner.*	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" section for Utilization Review service categories delegated to each partner.*	ProgenyHealth	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

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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 **365 calendar days** from the last day of service.

Out-of-Network Providers

Out-of-network providers in Michigan shall submit all claims **within 365 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 Michigan Department of Insurance and Financial Services (DIFS), which stipulate that all undisputed claims requiring additional information must be processed and paid or denied within **45 calendar days**, unless otherwise set forth by 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 **365 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 and Late Fees

Interest on Late Payments: Oscar and its delegated provider organizations will pay interest at a rate of **twelve percent (12%) 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 non-emergent services 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 all requested additional information is received.

Interest on Underpayments: If Oscar processes a claim incorrectly and fails to adjust the clean claim within 45 calendar days from the date the clean claim was received, interest on the adjusted payment amount (excluding copayments, coinsurance amounts, and deductibles), is due beginning 45 days 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. The provider must issue the refund or submit a clear, written explanation of why the refund request is being contested within **365 calendar days** of the date the notice of overpayment was received.

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

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
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