oscar

New York

STATE MANUAL 2017

New York Provider Manual

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Provider Manual Updates

The following updates have been made to the Provider Manual:

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- Added hours of operation

Section: Oscar at a Glance
- 2017 Member ID card and revised table focusing on 2017 claims information

Section: Our Network Partners
- Revised table showing network partners effective 2017 and their claims addresses

Section: Claims and Payment
- Updated address for refund checks or written notices to: Attn: Oscar Insurance Operations 295 Lafayette Street, 6th Floor, New York, NY 10012
- Timeframes for claims submissions revised and new mailing address added

Section: Quality Management Program
- New Potential Quality Issues (PQI) process
- Updates to “Professional resources for Behavioral Health” subsection
- Language update: “Optum is the contracted Behavioral Health Management company for Oscar”

Section: Access to Care
- Language update: "Oscar is an EPO network" changed to "Oscar is an Exclusive Provider Organization ("EPO") plan."
- Additional information on criteria for termination from Oscar’s network

Section: Member Grievances
- Language updates to Overview Section

Section: Provider Inquiries and Disputes
- Updated mailing address to: P.O. Box 52146 Phoenix AZ, 85072–2146

Section: Forms
- New Potential Quality Issue (PQI) Referral Form
- Address change on Provider Dispute Resolution Form
- Address change on Member Grievances Form

Introduction

Welcome to Oscar.
We think health insurance should be smart, simple, and friendly. That's why we built Oscar, and we're so glad to be working with you. Our goal is to change the way providers and consumers interact with healthcare by using technology, design, and data.

This document is a guide for how to work with us, and you can always find the latest copy on our website. If you ever have questions, please don't hesitate to reach out to us.

We look forward to working together!

Our Philosophy
Great health insurance starts with a great network. We're partnering with forward-thinking providers and world-class health systems to change healthcare for the better. We want to make it simple for you to manage your practice so you can focus on providing care. Best of all, we're here when you need us. Welcome to the Oscar family.

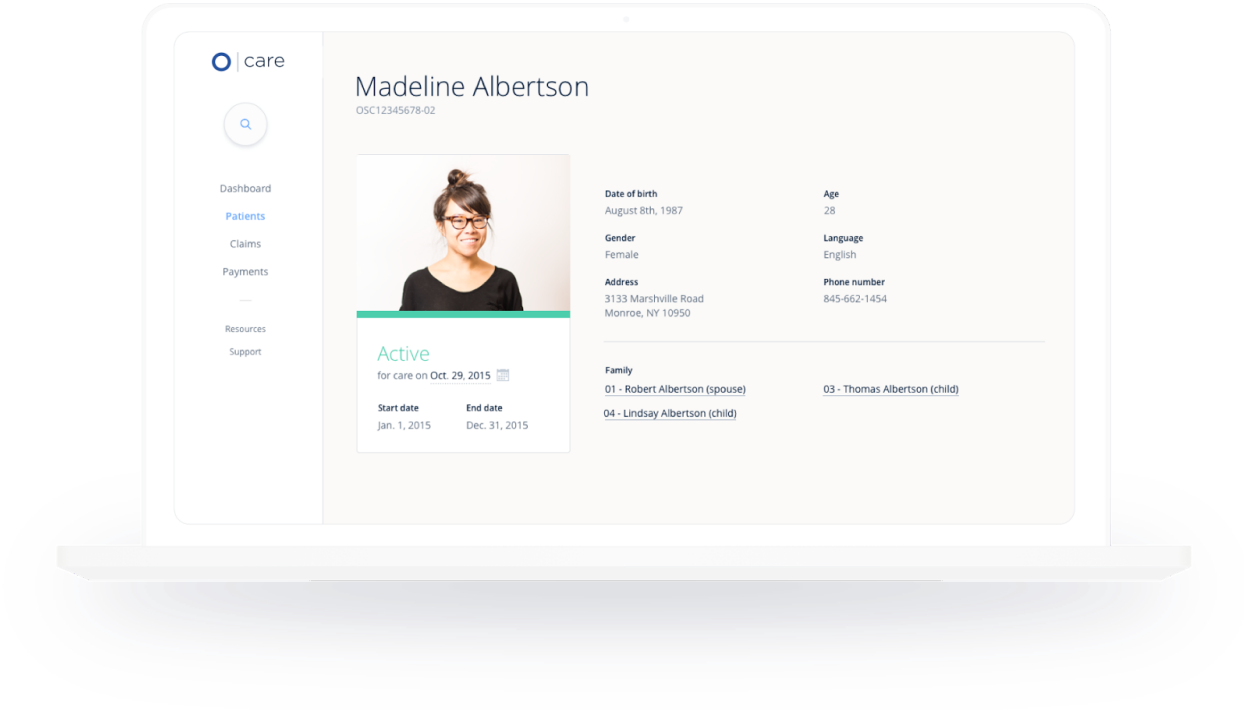
Questions? We're here to help.

Phone
1-855-OSCAR-55

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

Hours of Operation
Mon-Fri 8am-6pm

Meet Oscar Care



Oscar Care is where you'll find everything you need to work with Oscar. We built the site to simplify your team's workflows so that you can focus on delivering great care to our members. Go to provider.hioscar.com to:

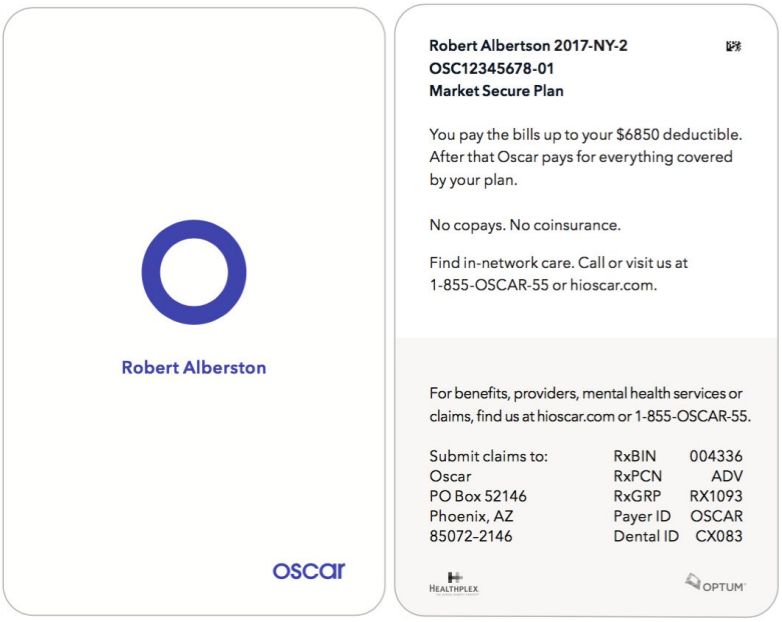
- Request to join the network.
- Browse resources such as:
    - Provider Manuals for California, Texas, New York, and New Jersey
    - Important policies and forms
- Search our provider directory for in-network specialists, lab facilities and more.
- Search our drug formulary to find out what medications Oscar covers.
- Create a login for your team to check member eligibility, benefits, claims status, and which outpatient procedures require prior authorization.

Oscar at a Glance

Here's how to work with us.

Check Eligibility and Benefits
Visit provider.hioscar.com or call 1-855-OSCAR-55. Our hours of operation are Mon-Fri 8am-6pm.

Member ID Card



Care Management
For diabetes care, cardiac care, or complex care management, refer patients to call 1-855-OSCAR-55. Our Care Managers provide dedicated support to patients who need it.

Find In-Network Partners
Search for in-network providers, lab facilities, pharmacies, and hospitals on https://www.hioscar.com/search.

Pharmacy
CVS/Caremark manages our pharmacy benefits. For drug authorizations, call 855-RX-OSCAR, or initiate one electronically at www.covermymeds.com/epa/caremark.

Laboratory

Providers must send lab work to an in-network lab facility. Note: some Oscar plans include free labs from Quest Diagnostics. Search our online directory for in-network labs and confirm member lab benefits at provider.hioscar.com.

Prior Authorization

To confirm which outpatient procedures require prior authorization log into provider.hioscar.com. To request a prior authorization or check the status of an existing authorization, call 855-OSCAR-55. Review this manual's prior authorization section for specific services that require preauth.

Submit claims

Claim type	Network	2016 Services	2017 Services
Medical Services	2017 Plan Year: Oscar 2016 Plan Year: MagnaCare	Electronic Payor ID: **11303** MagnaCare PO Box 1001 Garden City, NY 11530	Electronic Payor ID: **OSCAR** Oscar Insurance Corporation PO Box 52146 Phoenix, AZ 85072 – 2146
Behavioral Health and Substance Abuse Services	2017 Plan Year: Optum 2016 Plan Year: ValueOptions/ Beacon Health Options	ValueOptions PO Box 1347 Latham, NY 12110	Electronic Payor ID: **87726** Optum P.O. Box 30757 Salt Lake City, UT 84130-0757
Pediatric Vision Services	Davis Vision	Vision Care Processing PO BOX 1525 Latham NY 12110	Vision Care Processing PO BOX 1525 Latham NY 12110
Pediatric Dental Services	HealthPlex Dental	HealthPlex Inc Attn: Claims Dept PO Box 9255 Uniondale NY 11553	HealthPlex Inc Attn: Claims Dept PO Box 9255 Uniondale NY 11553
Prescriptions/ Specialty Pharmacy	CVS/Caremark	CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136	CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136

Our Providers

Overview

To help make working with Oscar simple, this manual was created with direction and guidance around the basic operational processes of providers and provider organizations. Please note, however, that provider organizations are responsible for distributing copies of this Provider Manual to its in-network providers.

Provider Training

All contracted providers and provider organizations are required to provide appropriate training for employees and applicable subcontractors within 90 days of hire and annually. Oscar will review documentation of the training during the delegation audit or more frequently if issues arise.

Provider Review Requirements

Where applicable, providers must agree to permit the Department of Financial Services (DFS), or any other regulatory body as required, to conduct on-site evaluations periodically in accordance with the current state and federal laws and regulations and to comply with the agency's recommendations, if any. Providers must give DFS, HHS, the GAO, any Peer Review Organization (PRO) or accrediting organizations, their designees, and other representatives of regulatory or accrediting organizations the right to audit, evaluate, or inspect books, contracts, medical records, patient care documentation, other records of contractors, subcontractors or related entities for services provided on behalf of Oscar for the time period required by applicable law following the termination of the contract or the completion of an audit, whichever is later.

Provider Insurance Requirements

Throughout the term of the contract, providers must maintain a malpractice, general liability and any other insurance and bond in the amounts usual and customary for Covered Services provided with a licensed managed care company admitted to do business in the State and acceptable to Oscar. In the event providers procure a "claims made" policy as distinguished from an occurrence policy, providers must procure and maintain prior to termination of such insurance, continuing "tail" coverage or any other insurance for a period of not less than five (5) years following such termination. Providers must immediately notify Oscar of any material changes in insurance coverage or self-insurance arrangements and must provide a certificate of insurance coverage to Oscar upon Oscar's

request. Copies of insurance policies and/or evidence of self-insurance must be provided to Oscar upon request.

Compliance with the Americans with Disabilities Act (ADA)

Oscar employees, business partners and contracted Provider Organizations must comply with ADA requirements, including compliance with Section 504 of the Rehabilitation Act which requires that electronic and information technology be accessible to people with disabilities and special needs. Web pages, portals and other electronic forms of communication are compliant with these standards. Any documents provided on member-based portals are compliant with the Section 504 standards allowing the use of assistive reading programs.

If you or your patients have any comments or questions about content and accessibility, please contact Oscar's Member Services department toll free at 855-OSCAR-55.

Language Assistance for Persons with Limited English Proficiency (LEP)

Oscar assesses the linguistic needs of its enrollee population to ensure members have access to translation and interpretation services for medical services, customer service, and health plan administrative documentation, as needed and according to state regulations. Oscar also ensures member access to translated or alternative format documents and communication as necessary, including for the visually and hearing impaired.

Members requiring interpreter services can contact Oscar's Member Services number below to access the Language Line toll free: 1-855-OSCAR-55.

Delegated providers are required to follow the policies and procedures established by Oscar to ensure those members with limited English proficiency receive appropriate interpretative and translation services.

Confidentiality and Protected Health Information (PHI)

Oscar and its Provider Organizations are considered "Covered Entities" under the Privacy Rule, implemented pursuant to HIPAA and must comply with the strictest applicable federal and state standards for the use and disclosure of PHI. Oscar and its providers are required by federal and state laws to protect a member's PHI and are also required to report any breach in confidentiality immediately. Oscar maintains physical, administrative, and technical security measures to safeguard PHI; it is important that any delegated entities maintain these safeguards of PHI as well.

Related policies:
Privacy and Confidentiality Practices

Our Network Partners

Overview

For mental health and substance abuse, pediatric dental, and pediatric vision services, Oscar engages with the network partners listed below. Providers of these services must be in the respective partner's networks, and claims must be submitted to the address listed. Oscar network partners also handle contracting, credentialing, and utilization management and review for these services.

Service	Network Partner	2016 Claims Address	2017 Claims Address
Behavioral Health and Substance Abuse Services	2017 Plan Year: Optum 2016 Plan Year: ValueOptions/ Beacon Health Options	ValueOptions PO Box 1347 Latham, NY 12110	Electronic Payor ID: **87726** Optum P.O. Box 30757 Salt Lake City, UT 84130-0757
Pediatric Vision Services	Davis Vision	Vision Care Processing PO BOX 1525 Latham NY 12110	Vision Care Processing PO BOX 1525 Latham NY 12110
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Prescriptions/ Specialty Pharmacy	CVS/Caremark	CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136	CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136

Our Members

A Better Member Experience

Many of Oscar's individual and family plans include great benefits like free primary care, mental health, OBGYN visits, preventive care, and generic drugs.

Member's Rights and Responsibilities

In addition to access to great providers, we ensure the following rights and responsibilities for Oscar members:

- A right to receive information about Oscar, its services, its practitioners and providers and member rights and responsibilities. For more information please see Oscar's website at www.hioscar.com or call member services at 855-OSCAR-55.
- A right to be treated with respect and recognition of their dignity and their right to privacy by all providers, practitioners, Oscar contracted vendors and Oscar staff.
- A right to participate with practitioners and providers in making decisions about their health care.
- A right to a candid discussion with their practitioners and providers of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice grievances or appeals about Oscar and its contracted providers and practitioners regarding the care or services they provide. Grievances may be communicated by calling member services at 855-OSCAR-55.
- A right to make recommendations regarding Oscar's member rights and responsibilities policy.
- A responsibility to supply information (to the extent possible) that Oscar and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Enrollment and Eligibility

Overview

An Individual who resides in the Plan Service Area, but is not entitled to or enrolled in Medicare Parts A/B and/or D, is eligible for Oscar coverage. The Subscriber's spouse or Domestic Partner and all Dependent children (including those who qualify under a "Qualified Medical Child Support Order") may also be eligible to enroll with Oscar at the same time. Qualified individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified individual has experienced a qualifying event.

Open Enrollment Period

The annual open enrollment period for individual health insurance plans is designated by the Department of Health and Human Services. Individuals may enroll in an Oscar plan, switch from another plan to Oscar or from Oscar to another plan, and apply for subsidies within this period. This is the only time period during which individuals may obtain an Oscar individual plan, both off or on the health insurance marketplace, unless the individual has a qualifying life event and qualifies for special enrollment.

Special Enrollment Period

A special enrollment period is a period during which a qualified individual (together with his or her spouse and dependents, if applicable), experiences a qualifying life event or changes in eligibility, outside of the open enrollment period. Individuals may enroll in an Oscar plan, switch from another plan to Oscar or from Oscar to another plan.

Verifying Eligibility

Providers are responsible for verifying member coverage and benefits prior to rendering any non-emergency services or treatments.

Providers can confirm member eligibility by:

Checking online at provider.hioscar.com
Calling customer service at 1-855-OSCAR-55

All Oscar members receive and should present to you a Member Identification Card (ID) with the following information (sample ID included in the Appendix):

- Name of the Member's plan
- Policy #
- Member ID #
- Member first and last name
- Contact information for claims and member services

Oscar will not pay claims for members not eligible at date of service or individuals not covered by Oscar.

Grace Periods

For members not receiving advance payments of the tax credit: Oscar provides a grace period of 30 days to members who are not receiving advance payments of the premium tax credit and who have previously paid at least one full month's premium during the benefit year. During the grace period, the policy will remain active. If any premium is not paid by the end of the grace period, coverage will be terminated as of the end of the period for which premium has been paid. Any payments made to a provider on behalf of a member who ultimately loses coverage due to non-payment of premiums will be refunded to Oscar by the provider within forty five (45) days of receipt of written request by Oscar. Any amounts not paid within forty five (45) days of receipt of notice from Oscar may be offset by Oscar from amounts otherwise owed to the provider without any further action required. Oscar will deny claims that are received and not processed with dates of service beginning on the last day the premium was paid after Oscar has confirmed that the grace period expired without premiums being paid in full.

For members receiving advance payments of the premium tax credit: Oscar provides a grace period of three consecutive months to members receiving advance payments of the premium tax credits who have previously paid at least one full month's premium during the benefit year. During the grace period, the Oscar will:

1) Pay all appropriate claims for services rendered to the member during the first month of the grace period and pend and/or deny claims for services rendered to the enrollee in the second and third months of the grace period; and,
2) Notify providers at the time the provider confirms the member's eligibility of the possibility for denied claims when a member is in the second and third months of the grace period.

If a member receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums, Oscar will terminate the member's coverage on the last day of the first month of the 3-month grace period and deny claims incurred during months two and three of the 3-month grace period. Any payments made to

providers on behalf of members who ultimately lose coverage due to non-payment of premium with dates of service beginning after the first month of the 3-month grace period will be refunded to Oscar by the provider within forty five (45) days of receipt of written request by Oscar. Any amounts not paid within forty five (45) days of receipt of notice from Oscar may be offset by Oscar from amounts otherwise owed to the provider without any further action required. Oscar will deny claims that are received and not processed with dates of service beginning after the last day of the first month of the 3-month grace period after Oscar has confirmed that the grace period has expired without premiums being paid in full.

If the member pays in full during the 3-month grace period, claims will be processed as usual.

Claims and Payments

Overview

Providers may submit claims for verified, eligible members electronically or via mail. In-network providers will be reimbursed according to the rates established in their Provider Agreements. This section outlines Oscar's claims processes and policies.

Claims Submission

Oscar highly recommends that providers submit claims electronically via Eligible or Emdeon.

If you are having any issues setting up the ability to submit claims electronically, please contact your billing vendor to ensure they have Oscar's payor ID in their system.

2016 Claims

Claims with **dates of service beginning on or before December 31, 2016** should be submitted electronically using Oscar's previous Payor ID: **11303**.

If a claim cannot be submitted electronically, a paper UB-04 or CMS 1500 should be submitted to:

MagnaCare
PO Box 1001
Garden City, NY 11530

2017 Claims

Please note: Providers currently in-network with Oscar through Oscar's partnership with MagnaCare will need to set up a new electronic claims submission profile to use for submitting 2017 claims.

Any claims with **dates of service beginning on or after January 1, 2017** should be submitted electronically using Oscar's new Payor ID: **OSCAR.**

If a claim cannot be submitted electronically, a paper UB-04 or CMS 1500 should be submitted to:

Oscar Insurance Corporation
PO Box 52146
Phoenix AZ, 85072–2146

Timely Filing of Claims

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 a provider to submit claims will be **120 days** from the last date of service. Late charges or bills to a previously submitted claim must be received within 180 days of the last date of service, or the timely filing deadline in the contract, whichever is earlier. If a provider enters into a formal dispute resolution process with Oscar, the provider should refer to the timeliness guidelines in the Dispute Resolution Section of this manual.

Providers must claim benefits by sending Oscar properly completed claim forms itemizing the services or supplies received and the charges. Oscar will not be liable for benefits if Oscar does not receive completed claim forms within this time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Claim Forms

For all claims submitted via mail, Oscar requires the CMS 1500 Form for professional services and the UB-04 Form for facility services.

CMS 1500 Form: Required for all physician services claims, including internal medicine, gynecology, and psychiatry. The International Classification of Diseases (ICD-10) diagnosis codes and HCPCS/CPT procedure codes must be used. All field information is required unless otherwise noted.

UB-04 Form: Required for all institutional services claims. All field information is required unless otherwise noted.

Both claim forms are available in the Forms section of this manual. If unlisted or miscellaneous codes are used, notes and/or a description of the services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment and should be avoided to the extent possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may be denied, and the member may not be held liable for payment.

Requests for Additional Information

During the claims adjudication process, Oscar will sometimes ask a provider for additional information—such as medical records, acquisition invoices, or itemized bills—in order to better ascertain financial liability and whether or not the services on the claim should be covered. Oscar will make any requests for more information within **30 calendar days** of receiving the claim.

Providers are expected to submit the requested information to Oscar, along with the original claim and a copy of the information request letter, within **90 working days** of receipt of the request. The requested documents should be sent to:

Oscar Insurance Corporation
PO Box 52146
Phoenix AZ, 85072–2146

Oscar will process the claim within **30 working days** of receipt of all necessary requested information.

Timely Processing of Claims

Oscar and its delegated Provider Organizations and Hospitals are required to meet the claims timeliness standards established by each provider's contract. For claims from non-contracted providers, Oscar will abide by the guidelines of the New York Department of Financial Services (DFS), which stipulate that all undisputed claims must be processed and paid or denied within **30 calendar days**.

Interest Payments

Interest on Late Payments: Oscar and its delegated Provider Organizations will pay interest at a rate of twelve percent (12%) per annum 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. 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 denied with a request for additional information, the timely payment deadline will be calculated from the date the requested additional information was received.

Interest on Underpayments: If Oscar processes a 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 was received.

Good Faith Payments

If Oscar determines that it has denied or reimbursed a claim correctly but agrees to overturn the denial or issue additional payment in the interest of the member, these "Good Faith Payments" will not be eligible for any interest or penalties related to late payment.

Incomplete Claims

Claims that are determined to be incomplete due to incorrect or missing required information (e.g. invalid CPT codes) will be denied. Providers will need to re-submit these claims with the appropriate information for the claims to be adjudicated.

Claim Denials

Oscar will send a letter to members in situations where a denied claim could lead to member financial responsibility. This letter will include the reason for denial as well as an explanation of appeal rights.

Claim Corrections and Late Charges

Providers who believe they have submitted an incorrect or incomplete may submit an updated claim within the relevant timely filing period indicated above in the Timely Filing of Claims section.

Claims for Emergency Services

Emergency services do not require prior authorization. However, post-stabilization services without prior authorization require notification and may be subject to concurrent or retrospective review and medical necessity determination.

Claims Overpayment

Should Oscar determine that it has overpaid a claim, Oscar will submit a written refund request to the provider. This request will include the patient's name, date(s) of service, amount of overpayment, all interest and/or penalties associated with the overpayment, and an explanation of how Oscar determined that an overpayment had been made. Oscar must make any refund requests within **two years (730 calendar days)** of the date of payment of the affected claim.

Upon receiving this request, the provider must issue the refund or submit a clear, written explanation of why the refund request is being contested within **45 working days** of the date the notice of overpayment was received. If the provider contests the refund request, the provider must identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

Providers should send refund checks or written notices contesting refund requests to:

Oscar Insurance Corporation
295 Lafayette Street, 6th Floor
New York, NY 10012

Should the provider fail to issue the refund or notify Oscar of a contested overpayment within 45 working days, the amount of the overpayment may be deducted from future claims payments until Oscar has been fully reimbursed. A written explanation will accompany all deductions made from future claims payments.

Collection of Cost Share

Covered services provided to Oscar members may be subject to a deductible, a coinsurance amount, or a copayment amount. In these cases, the member will be liable for reimbursing the provider the relevant amount.

Oscar encourages providers to collect copayments upfront but to defer the collection of coinsurance amounts and outstanding deductibles until Oscar has adjudicated the claim and an Explanation of Payment (EOP) has been received. If a provider prefers to collect coinsurance amounts and outstanding deductibles upfront, Oscar encourages the provider to check with the member whether the member expects other medical or prescription spending to occur on that day. If the member anticipates further spending, Oscar encourages the provider to account for those amounts in the upfront collection.

If a provider collects an upfront amount that exceeds the member’s cost share indicated in the EOP, Oscar requires the provider to issue a refund to the member within **10 working days** of receipt of the EOP.

Copayment and coinsurance amounts for the most common services are indicated on a member's ID card. Providers can also check a member's outstanding copayment amount, coinsurance amount, or deductible by calling Oscar Member Services at 1-855-OSCAR-55 or logging onto provider.hioscar.com.

Balance Billing

Except for copayments and deductibles, providers must not invoice or balance bill Oscar members for the difference between the provider's billed charges and the reimbursement paid by Oscar. Additionally, if providers do not comply with rules laid out in their contracts, in this manual, or by state regulators (e.g. timely filing, surprise bills, pre-authorization checks, etc.), providers cannot hold members liable for payment.

NY Surprise Bills

Oscar will comply with the surprise bill regulations put forth by the New York DFS and will pay out-of-network claims that qualify as surprise bills under these state guidelines.

Oscar will pay surprise bill claims at 55% of the usual, customary, and reasonable (UCR) rate assigned to each procedure code. UCR rates are set at the 80th percentile of the non-discounted charges listed in the FAIR Health national benchmark database for the relevant geographic area and time period. On average, the allowed value for the claims that Oscar has paid is 51% of UCR. This calculation accounts for all professional claims and excludes any office-administered medication.

To avoid surprise bill situations, Oscar asks providers to make their best effort to refer members to in-network Oscar providers and labs. Providers are encouraged to call Oscar if they have a question about whether a specific provider or lab is in Oscar's network. Further information on surprise bills is included in the Appendix Section.

Patients, providers, and health plans have access to an Independent Dispute Resolution (IDR) process by which an Independent Dispute Resolution Entity (IDRE) will review disputed claims reimbursed as surprise bills and determine the most appropriate payment. This dispute resolution pathway is also available for out-of-network emergency payables. Oscar or the provider must file an IDR application (included in the Forms section) on behalf of any member who wishes to initiate a dispute.

Reimbursement Policies

Oscar reimburses in-network providers according to the policies attached in the Appendix. Oscar may modify reimbursement policies at any time by publishing new versions in this manual. Refer to the Appendix for Oscar's reimbursement policies.

Related forms and policies:

CMS 1500 Claim Form
UB-04 Claim Form
Independent Review Process Application

Benefits Assignment Form
Surprise Bills and How to Submit a Claim
Guide to the Independent Review Process
Reimbursement Policies

Utilization Management

Overview

Oscar's Utilization Management (UM) Program promotes the delivery of high quality, medically necessary, cost efficient care for members. The UM Plan outlines policies and procedures by which Oscar determines medical necessity, access, availability, appropriateness, and efficiency for clinical services and procedures based on a member's health benefits.

Oscar's Utilization Review (UR) activities include pre-service (precertification or prior authorization), concurrent, and post-service (retrospective) reviews.

It is important to note that neither prior authorization nor notification is required for Emergent or Urgent Care. Oscar does not require a primary care physician (PCP) and thus does not require review for referral to specialists or any other provider in the Oscar network.

Oscar maintains a UR process to:

Gather pertinent clinical information for each case
Apply case-specific criteria based on an individual's characteristics (e.g., age, comorbidities, family health history, and other factors)
Notify providers and members of the utilization decision according to the timeframes outlined below for approvals and denials

Authorization is provided when a requested service is a covered benefit, deemed medically necessary, and provided in the most efficient and cost effective manner without compromising quality of care. Benefits are provided only for services that are medically necessary.

Clinical Criteria and Guidelines

Oscar's UM program applies Milliman Care Guidelines (MCG) as its core clinical criteria set. MCG are national, standardized benchmark criteria developed with input and involvement from physicians and other licensed healthcare providers and based upon generally accepted medical standards. Oscar currently uses MCG 20th edition criteria (released March 2016) and incorporates interim updates as they are released. MCG are reviewed and updated regularly by Milliman.

For the services listed below, Oscar partners with outside vendors. Oscar's partners have their own specialty criteria, which are reviewed and approved annually by Oscar's State Medical Director.

	Service categories and criteria delegated for UR
eviCore healthcare (previously CareCore National)	Medical: specialty outpatient services Cardiac imaging Genetic testing Medical and radiation oncology Musculoskeletal management (including physical and occupational therapy, chiropractic, speech therapy, and injections for pain management) Radiology Sleep therapy and diagnostics
CVS/Caremark	Prescription medication
ValueOptions/Beacon Health Options	Behavioral health and substance abuse (2016)
Optum	Behavioral health and substance abuse (effective 1/1/2017)
HealthPlex Dental	Pediatric dental
Davis Vision	Pediatric vision

Authorization Requests and Communication

Providers are able to review which outpatient procedures require prior authorization by logging into provider.hioscar.com, and request authorization by contacting Oscar at 855-OSCAR-55. In cases where a partner is used for a specific service type or service area, calls are transferred according to the phone prompts. Please note, for services reviewed by eviCore, providers may also submit an authorization online at www.carecorenational.com. An Authorization Request Form is also included in the Forms section.

All determinations or requests for more information in order to make an initial UR determination are made in a timely fashion appropriate for the member's specific condition, not to exceed the time frames required by State and/or Federal regulations. Decisions are communicated both verbally and in writing to members and providers, as required by regulations.

Oscar will not reverse a UM decision where the provider relied upon written or oral authorization of Oscar (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud.

Program Staff

Oscar's New York Medical Director is ultimately responsible for the New York UM Program. With a full, unrestricted license to practice medicine issued by the state of New York, the New York Medical Director maintains authority over all New York UM activities, including implementation, supervision, oversight, and evaluation of the Program. This includes ultimate oversight and accountability for all adverse determinations relating to members in a New York Oscar plan, whether made by an Oscar employee or delegated utilization review agent.

Please note, any adverse determinations (medical necessity denials) are reviewed and ultimately made by a physician who holds an unrestricted license issued by the state of New York.

Services Requiring Prior Authorization

Oscar requires authorization on the services listed below. Please submit any elective or pre-service requests in advance to ensure everything is in place for your patients to get the right care!

To confirm requirements for a specific code or service, search at provider.hioscar.com or call 1-855-OSCAR-55. You can use this same phone number to request authorization and check status of an existing authorization. For services where Oscar delegates utilization review, you will be transferred to the appropriate partner.

Medical
Review for certain services (indicated by an *) is delegated to eviCore healthcare. For these requests you can generally submit online at www.evicore.com. For all others, you can call 855-OSCAR-55 or follow the instructions on the Oscar authorization request form (attached to this manual).

Inpatient – all non-emergent

- Acute inpatient
- Rehabilitation facility
- Skilled nursing facility

Durable medical equipment (DME), prosthetics, and orthotics

- Cochlear implants & accessories
- Hospital grade breast pump
- Sleep equipment & accessories
- Any item with an annual cost of $500 or more

Outpatient (the following services only)

- Ambulance (non-emergent only)
- Bariatric surgery
- Cardiac imaging (cardiac catheterization, transthoracic echocardiogram)*
- Cosmetic / reconstructive procedures
- Genetic testing*
- Home health (all services)
- Hyperbaric oxygen
- Immunoglobulin (IVIg)
- Infertility treatment
- Interventional pain management*
- Medical oncology*
- Physician-administered biologics*
- Prenatal ultrasound (precert required only after the first 3)*
- Radiation oncology*
- Radiology (CDT, CT, MRI/MRA, MRCP, nuclear medicine, PET)*
- Rehabilitation services (PT/OT/Chiropractic/Speech)*
- Sleep therapy and equipment*

Behavioral health and substance abuse

In 2016, authorizations for behavioral health and substance abuse are handled by Beacon Health Options.

All Inpatient Services (non-emergency)

- Rehabilitation
- Skilled Nursing
- Subacute Care

Partial Hospitalization Treatment

Effective 1/1/2017, authorizations for behavioral health and substance abuse will be handled by Optum. You may contact Optum at 877-855-1317 for more information.

Prescription medication

Pharmacy benefit authorizations are done by CVS/Caremark. To learn whether a medication requires auth or step therapy, check Oscar's formulary or call 855-RX-OSCAR.

NCQA affirmative statement

Staff are available at least 8 hours per day during normal business hours, and outside normal business hours for expedited requests. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. A language line is available (via the main Oscar phone number, 855-OSCAR-55) for callers requiring interpretation. Members can access TDD/TTY services via the TRS hotline by calling 711.

Oscar notifies members and practitioners, providers, and employees who make UM decisions affirming:

- UM decision making is based only on appropriateness of care and service and existence of coverage
- Oscar does not specifically reward practitioners or other individuals for issuing denials of coverage
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization

Emergency, Urgent, and Ambulance Services

No prior authorization is required for emergent or urgent services, including emergency ambulance. Post-stabilization care and services require notification and may be subject to review and medical necessity determination. Members who reasonably believe they have an emergent medical condition that requires an emergency response are encouraged to appropriately use the 911 emergency response system where available. Emergency ambulance services are covered from the site of the medical emergency to the nearest appropriate facility or between facilities when a higher level of care is required to stabilize and treat an emergency medical condition.

Experimental and Investigational Treatments

Oscar is responsible for all decision-making related to experimental and investigational treatments. Providers must submit to Oscar a request for any treatment, therapy, procedure, or drug (or usage thereof) that may be experimental or investigational, including pertinent medical records. These requests will be referred to an appropriate reviewer for evaluation and determination of authorization in accordance with applicable benefits and acceptable standards of care.

Experimental or investigational services are defined as:

> Treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply that is not

recognized, in accordance with generally accepted medical standards, as being safe and effective for use in the treatment of an illness, injury, or condition at issue.

Services that require approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered.

Services or supplies that are not approved or recognized, in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients.

Providers are responsible for notifying Oscar that a member wishes to participate in a clinical trial. Services covered under the umbrella of the clinical trial will not be subject to payment. An example of a potential non-covered service that might be covered under the clinical trial would be periodic lab testing required under the scope of the clinical trial.

Delegation and Oversight

Oscar contracts with partners to conduct UR for certain service categories, as detailed in the *Clinical Criteria and Guidelines* section above. In these cases, Oscar UM staff is responsible for oversight of the delegated vendor for both clinical and operational purposes. The New York Medical Director has final oversight and authority over any UR determinations and may overturn any adverse determination made by a delegate.

Monitoring and Reporting of UM

Oscar retains documented UM policies and procedures as specified within the UM Plan and as required by federal and state regulation. You may contact Oscar Provider Relations with any questions about the UM plan and related documentation, including but not limited to:

UM Plan, policies, and procedures, including clinical criteria and guidelines

Utilization records including prior authorization approvals and denial letters

Case management records

Evidence of appropriate licensure, including of physician and other clinical reviewers responsible for conducting utilization reviews

Oscar has utilization and claims management systems to identify, track, and monitor care provided to members and to ensure its appropriateness. Oscar does not reward

practitioners, providers, or employees who perform utilization reviews. Utilization decisions are based on medical necessity or lack of covered benefit.

Oscar requires that any delegated utilization agent provide a daily electronic feed of utilization data via secure FTP or similar. This feed includes all utilization decisions (approval, denial, and other).

Related forms:
Authorization Request Form

Quality Management

Overview

Oscar is dedicated to providing best-in-class experience and quality of healthcare for Oscar members. Oscar's vision is to re-invent how a health plan functions and its role in the lives of its members, and Oscar's quality strategy and structure provides the foundation to achieve that vision. Oscar is focused on improving outcomes with innovative quality reporting, case management, care coordination, disease management, compliance activities, and programs to reduce hospital admissions, improve patient safety, reduce medical errors, and minimize health disparities.

All contracted Provider Organizations and their downstream providers are required to participate in Oscar's Quality Management and Continuous Quality Improvement (CQI) Program. Participation includes submission of encounter data, accurate and complete coding, and participation in review of potential quality issues and programs.

CQI and Performance Improvement

The purpose of the CQI Program is to improve health outcomes of members by providing access to affordable, appropriate and timely healthcare and services, which is routinely measured for compliance with established, evidence based standards. This objective is accomplished by accessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care.

The CQI Program also provides a framework to evaluate the delivery of healthcare and services provided to members. This framework is based upon the philosophy of Continuous Quality Improvement and includes the following considerations:

- Quality issue identification, oversight, corrective action plan assignment, and follow-up
- Oversight and monitoring of internal programs
- Tracking and trending identified plan and provider issues
- Utilization and medical management plans
- Management of Protected Health Information (PHI)
- Credentialing of practitioners and other providers
- Oversight of delegated entities for quality and medical management
- Disease management
- Case management
- Clinical practice guidelines
- Member Rights and Responsibilities

The responsibility for developing and providing oversight of the Medical Quality Program rests with the CQI Committee. In order to foster communication with the practitioner and provider networks, as appropriate, practitioners and designated behavioral healthcare practitioners are invited to participate in the CQI Program through planning, design, implementation or review. Practitioners may attend the CQI Committee and/or attend and advise through involvement in various clinical subcommittees.

Quality Data and Reporting

Oscar captures and analyzes data to ensure Oscar programs and providers optimize care, including but not limited to:

- HEDIS data to measure performance on areas of care and service
- CAHPS data to measure member satisfaction and the experience of care
- Internal data from HRAs and on service utilization, cost, and quality
- Complex case and disease management management logs and notes
- Practitioner performance and effectiveness of incentives

Oscar does not delegate quality management to any outside entity but rather conducts oversight of delegated entities. Delegated organizations and providers must provide quality metrics for review by the CQI committee, including but not limited to periodic reporting of:

- Complex case management summary
- Disease management summary
- Utilization management
- Performance improvement initiatives, findings, and corrective action

Preventive Health and Wellness Initiatives

Oscar's goal is to meet and exceed all the highest clinical and customer quality standards and reporting requirements, specifically the utilization and quality measures of Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Health Care Providers and Systems (CAHPS survey).

Clinical Practice and Preventive Health Guidelines

Clinical practice guidelines, preventive health guidelines, and other internal criteria provide direction and standards for preventive, acute, and chronic care health services relevant to Oscar's enrolled membership. Guidelines address a range of clinical needs, focusing on high-volume and high-risk conditions and are reviewed, updated, and approved by the Quality Management Committee at least once annually. Performance and compliance with guidelines is monitored annually to ensure adherence and to identify educational opportunities for improvement. Clinical practice guidelines are reviewed against UM

criteria and member education materials to ensure consistency and alignment with appropriate medical recommendations.

Oscar is committed to the philosophy that Evidence Based Guidelines are known to be effective in improving health outcomes. Oscar compiled a group of recognized resources that promulgate Evidence Based Clinical Practice Guidelines.

Agency for Healthcare Research and Quality (AHRQ)
Evidence-based Guidelines

National Guideline Clearinghouse
www.guideline.gov

US Preventative Services Task Force
The Guide to Clinical Preventive Services includes U.S. Preventive Services Task Force (USPSTF) recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic.
http://www.uspreventiveservicestaskforce.org/

National Heart, Lung and Blood Institute
The EPR-3 Summary Report 2007, provides key information from the full report on the diagnosis and management of asthma. Summary information is provided on measures of assessment and monitoring, education for a partnership in asthma care, control of environmental factors and comorbid conditions that affect asthma, and medications.
http://www.nhlbi.nih.gov/guidelines/current.htm

Professional Associations for Primary Care Providers
American College of Physicians Resource for Clinical Practice Guidelines from the Annals of Internal Medicine http://www.annals.org

The American Congress of Obstetricians and Gynecologists (ACOG)
http://www.acog.org

American Academy of Family Practice
Compendium of AAFP endorsed clinical practice guideline from multiple professional medical associations, including American Academy of Pediatrics, AHA, and the AMA
http://www.aafp.org/home.html

American Academy of Pediatrics
Evidence-based decision making tools for managing common pediatric conditions
http://pediatrics.aappublications.org

Professional resources for Behavioral Health

Optum is the contracted Behavioral Health Management company for Oscar https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies.html

Disease Management

Oscar offers disease management for diabetes, cardiac disease, and complex conditions. Providers may refer Oscar members to call 1-855-OSCAR-55 to obtain more information on Oscar's disease management programs.

Health Management and Education

Oscar engages in health education to equip members with tools and resources to stay healthy, improve knowledge about chronic conditions and their treatment, learn behaviors for better self-management, and promote prevention and early detection of illnesses. Education efforts include telephone outreach, targeted online content, member engagement through Oscar's mobile app and website, and other tactics. Oscar evaluates outcomes using several mechanisms, including but not limited to HEDIS measures, utilization statistics, pharmacy data, and program participant surveys.

Member and Provider Satisfaction

Member satisfaction is a high priority and may be assessed by several sources, including but not limited to satisfaction surveys and appeals and grievances. Member complaints and appeals are assessed by reason category, provider, region, and delivery system.

Provider satisfaction may be assessed by satisfaction surveys, provider services complaints, and direct feedback offered by Provider Organizations. Satisfaction issues are categorized and assessed by severity and prevalence of the issue. Issues not meeting standards or performance benchmarks are identified and a Correction Action Plan for resolution and correction is implemented.

Potential Quality Issues

Definitions

Potential Quality Issue (PQI): is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care issue exists.

Quality of Care (QOC) Issue: is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.

Clinician or Provider: is any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity, if licensure or certification is required by State law or regulation.

Corrective Action Plan (CAP): is a plan approved by the appropriate quality improvement committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and time frames for completion.

Process

Oscar has a systematic method for the identification, reporting and processing of Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to Oscar members and to direct actions for improvement based upon the frequency and severity of the PQI.

It is Oscar's policy to accept a PQI referral through a variety of sources. These include but are not limited to: Internal referrals from Grievances and Appeals; a Plan member; a Plan provider; a Plan staff member; an affiliate.

All Potential Quality Issues which are identified will be tracked in the PQI log for the purposes of monitoring patterns to identify any potential trends or any significant sentinel events.

All information obtained during and used in a quality of care investigation will be held in strict confidence, according to the Plan confidentiality policies and in accordance with all relevant State and Federal Peer Review Laws and regulations.

A designated medical professional reviews all referred PQIs to identify whether a true Quality of Care issue exists afterwhich the case will be assigned a severity score. Some cases will be referred to the Peer Review/Credentialing Committee based on Oscar's policy. Based on review by the Credentialing Committee, a provider may be placed on a Correction Action Plan (CAP) or may be required to submit a Corrective Action Plan. The Corrective Action Plan will request follow up and evidence from the provider in question to demonstrate that the corrective actions have been implemented as specified.

All PQI outcomes are trended on a continuous 36 months' basis. Any identifiable trends, regardless of outcome to the member, will be referred to the Quality Improvement committee on a quarterly basis for potential action or educational opportunities.

Reporting

To report a PQI with your information or anonymously submit the PQI Reporting Form or complete and fax the **PQI Reporting Form** in the form section at the end of the manual.

Pharmacy Services

Overview

Oscar contracts with CVS/caremark to provide and coordinate the outpatient prescription drug benefit. CVS/caremark, on behalf of Oscar, is responsible for managing the pharmacy network, formulary, and all aspects of the outpatient prescription drug benefit, including any related medication management programs, approvals, denials and appeals. CVS/caremark adjudicates prescription claims at the point of sale.

Drug Formulary

The Oscar formulary is a dynamic document. Medications on Oscar's formulary generally remain consistent throughout any coverage year, but new medications and generics that become available are evaluated by Oscar's Pharmacy and Therapeutics (P&T) Committee and individual medications may be added to or removed from the formulary.

To access the drug formulary: https://www.hioscar.com/search/
To initiate a drug authorization: www.covermymeds.com/epa/caremark

Related forms:
Non-Formulary Marketplace Exception Form
CVS Formulary Exception Prior Authorization Form

Access to Care

Overview

Oscar is dedicated to providing access to high quality providers and strives to ensure strong network coverage for all of Oscar members' needs. Oscar will work with Oscar members and providers to ensure members have access to appropriate, timely and continued care.

Availability of Providers

Oscar is an Exclusive Provider Organization (EPO) plan. As such, members are not required to designate a specific PCP, but can see any in-network PCP they wish, and do not need a referral to see a specialist. The list of in-network providers and facilities by state can be found on the Oscar website.

Members do not have out-of-network benefits (except in an emergency). To create a streamlined experience, the following may be grounds for a provider's termination from Oscar's network:

- No admitting privileges to an in-network hospital
- Admitting members to out-of-network hospitals
- Performing procedures at out-of-network facilities
- Referrals to out-of-network providers (including laboratories)

Authorizing an Out-of-Network Provider

If it is determined that Oscar does not have an in-network provider with the appropriate training and experience needed to treat a member's condition, Oscar will approve an out-of-network authorization. Requests for out-of-network authorizations may be made by the member or an in-network provider.

Please note approvals will not be made on the basis of convenience for either a member or a provider, and Oscar may not approve the particular out-of-network provider requested. If Oscar approves the authorization, all services performed by the out-of-network provider are subject to a treatment plan approved by Oscar in consultation with the member, the member's PCP, and the out-of-network provider. All services rendered by the out-of-network provider will be paid as if they were provided by an in-network provider, and members are responsible for any applicable in-network cost-sharing. In the event that Oscar does not approve an authorization, any services rendered by the out-of-network provider will not be covered.

Transitional Care

Oscar understands that when providers leave the network or are terminated from the plan, members may require coverage for a period of time to ensure continuity of treatment.

As such, members who are being treated by a provider whose contracted status has been terminated may be able to continue ongoing treatment for covered services for up to 90 days after the effective date of termination. In addition, pregnant members in their second or third trimester may be able to continue care with a former in-network provider through delivery and any postpartum care directly related to the delivery.

Please note, members must contact Member Services to request this continuity of care and it must be authorized prior to service. Formerly in-network providers must agree to accept as payment the negotiated fee that was in effect just prior to the termination. Additionally, the provider must agree to provide Oscar with necessary medical information related to the member's care and adhere to Oscar's policies and procedures, including those for assuring quality of care, obtaining preauthorization, authorization, and a treatment plan approved by Oscar.

If a provider was terminated by Oscar due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with that provider is not available.

Credentialing

Overview

The Oscar network credentialing process is designed to provide initial and ongoing assessment of the provider's ability to render specific patient care and treatment within limits defined by licensure, certification and/or accreditation.

Oscar performs or provides oversight for all aspects of the credentialing process, including primary source verification of provider information and identification of potentially problematic providers. All providers that meet requirements are referred to the Credentialing and Peer Review Committee for final approval.

Re-credentialing of providers occurs every three (3) years. Information from Quality Management (QM), UM, Member Services, and Appeals & Grievances is considered at the time of recredentialing. Provider status and performance is continuously monitored between recredentialing cycles by Oscar or its delegated entity. Ongoing monitoring of reports by regulatory agencies of sanctions, limitations on licensure, and complaints are also performed between re-credentialing cycles.

If a reportable quality issue or trend is identified, the Credentialing and Peer Review Committee acts in accordance with Oscar's policies and procedures to take appropriate action. Oscar providers have the right to formal fair hearing and appeal if Oscar decides to alter the conditions of a practitioner's participation based on quality and/or service issues.

Oscar complies with applicable state and federal requirements and NCQA standards in credentialing and recredentialing its providers. Providers must maintain good standing with state and federal regulatory and licensing bodies.

Credentialing Delegation and Oversight

Oscar may delegate credentialing activities to contracted Provider Organizations that have administrative capacity to provide such services and meet delegation requirements as demonstrated in a pre-delegation review.

Oscar performs, and requires delegated entities to perform, ongoing internal audits to ensure the credentialing status of its providers remains current at all times. Audits include validation of licensure, malpractice, DEA, OIG and other sanctions, and current status of applicable certification and/or accreditation.

Non-Discrimination Policy

Oscar has the following processes and criteria in place to prevent discriminatory credentialing. Any delegated entities must similarly comply.

Tracking and trending of reasons for denial and/or termination

Semi-annual audits of files in process for greater than six (6) months to determine compliance with practitioner contact criteria

Non-discrimination clause on the “Statement of Confidentiality” signed by members, staff, and guests of the Credentialing Committee on an annual basis

Non-discrimination statement on Credentialing Committee attendance sign-in form

Information submitted to the Credentialing Committee for approval, denial or termination must not designate a provider’s race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or payer sources.

Member Grievances

Overview

Oscar has a process for timely hearing and resolution of member grievances in accordance with regulatory guidelines. The Head of Customer Care has primary responsibility for Oscar's grievance system and processing of grievances is not delegated to any other entity. Oscar performs ongoing review and analysis of grievances in order to track and trend issues. Analyses are reviewed by the Quality Management Committee and the Continuous Quality Improvement Committee, and recommendations are made to improve plan policies and procedures.

Filing a Member Grievance

Oscar provides assistance as needed to members filing grievances and maintains a toll-free number for the filing of grievances. Grievance forms and a description of the grievance procedure are made available at the Oscar headquarters in New York, and on the Oscar website (www.hioscar.com).

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. Grievance forms will be provided promptly upon request. Members can also call Oscar's customer service line to get help in filling out a form. A written record is made for each grievance received by Oscar including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition.

Oscar's grievance system addresses the linguistic and cultural needs of its member population as well as the needs of members with disabilities. Oscar ensures there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance. Grievances will be addressed and resolved according to state regulations.

Provider Inquiries and Disputes

Overview

Providers who would like to make an inquiry may contact Oscar via phone, web, email, fax, or letter sent to the address specified on the EOP. Inquiries leading to the submission of adjusted claims or late submissions will be reviewed according to the timelines established in the claims submission section.

If a provider wishes to make a dispute they must do so using Oscar's Dispute Resolution Form submitted by mail or fax within 365 days of a claim processing decision. A copy of the Dispute Resolution Form can be found in the Forms section of this manual. This submission will trigger Oscar's Dispute Resolution Process. Once the Dispute Form is received, Oscar will send an acknowledgement letter to the provider. Oscar will seek to resolve disputes in 45 working days or to seek additional information needed to resolve the dispute within this timeline. If Oscar requests additional information to resolve a dispute, the provider has 30 working days to respond. Upon receipt of all required information, Oscar will then seek to resolve the dispute within 45 working days.

At any time during the Dispute Resolution Process either party may request a meet and confer, and if the meet and confer isn't effective either party may submit the dispute to Binding Arbitration.

Dispute Resolution Forms and other related communications may be mailed to:

> Oscar Insurance Corporation
> P.O. Box 52146
> Phoenix AZ, 85072–2146

Related forms:
Provider Dispute Resolution Form

Fraud, Waste, and Abuse (FWA)

Overview

At Oscar, Fraud, Waste and Abuse is taken seriously. Fraud is distinguished from abuse in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully, and intentionally.

Waste is overutilization, extravagant, careless or needless expenditure of healthcare benefits or services from deficient practices or decisions.

Abuse describes practices that either directly or indirectly result in unnecessary costs to the health plans but there was no intent to deceive or misrepresent. Abusive billing practices, on the other hand, may not result from “intent,” or it may be impossible to determine that this intent to defraud existed. Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject knowingly and willfully conducted an abusive practice.

Prevention of Fraud, Waste, and Abuse

If a provider or Provider Organization identifies potential FWA, they must report it to Oscar immediately. Oscar maintains a telephone and email FWA reporting system as a mechanism for Provider Organizations, providers, employees, members, and others to:

Report concerns and possible violations of law, regulations, policies, procedures;
Ask questions about the Compliance Program; and
Seek advice about how to handle compliance-related situations at work.

The FWA Reporting System is anonymous. All calls are treated confidentially, and senders/callers can remain anonymous if they so choose. Callers may be asked whether they are willing to identify themselves so that an issue may be followed up with the caller after the call ends. Retaliation against anyone who raises a concern is prohibited.

All compliance-related questions, concerns, or suspected problems can be directed to the Oscar Fraud Line at 844-677-2740.

Forms

Authorization Request Form

Authorization request form

*To request an authorization complete this form, attach relevant clinical info, and fax it to **844-965-9053.***

What is this form for?
- ✔ Pre-service, in-network medical auths that are reviewed by Oscar (not partner) staff
- ✔ Concurrent or post-service auth for ER to inpatient admission (even if out of network)

What is this form not for? *(for any of these, call 855-OSCAR-55 or visit provider.hioscar.com)*
- ✘ Requests where the physician or facility is out of network, unless for an emergent admission
- ✘ Auth for services reviewed by one of our partners, or to find out what requires auth
- ✘ Help finding an in-network provider or facility

Request submitted by (and how we can reach you)

Your name (first & last)	Phone & ext.	Fax

Patient

Name (first & last)	DOB	ID #
		OSC

Physician

Name (first & last)	NPI	TIN

Facility (if applicable)

◯ Inpatient ◯ Outpatient/ambulatory (incl. home & DME)

Facility name & address	NPI	TIN

Dates

Request is (check one): ◯ Pre-service ◯ Concurrent ◯ Post-service

Service start or admit date	Service end or discharge date	# of visits (if applicable)

Service

Procedure code(s) CPT/HCPCS/Revenue	*Include units (if applicable)*
Diagnosis code(s) ICD-10	

Notes (include your MEDUM case # if for an existing case)**:**

Fax this form to **844-965-9053 -** include clinical information for fastest response

Benefits Assignment Form

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in-network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician; OR

2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Your Name: _____

Your Address: _____

Insurer Name: _____

Your Insurance ID No.: _____

Provider Name: _____ **Provider Telephone Number:** _____

Provider Address: _____

Date of Service: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____

(Signature of patient) (Date of signature)

CMS 1500 Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ◯ (Medicare #) MEDICAID ◯ (Medicaid #) TRICARE ◯ (ID#/DoD#) CHAMPVA ◯ (Member ID#) GROUP HEALTH PLAN ◯ (ID#) FECA BLK LUNG ◯ (ID#) OTHER ◯ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT™S NAME (Last Name, First Name, Middle Initial)

3. PATIENT™S BIRTH DATE MM DD YY SEX M ◯ F ◯

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT™S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ◯ Spouse ◯ Child ◯ Other ◯

7. INSURED™S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED™S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT™S CONDITION RELATED TO:

11. INSURED™S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ◯ NO ◯

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ◯ F ◯

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ◯ NO ◯ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ◯ NO ◯

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ◯ NO ◯ ***If yes***, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED™S OR AUTHORIZED PERSON™S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

71b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ◯ NO ◯ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ◯ EIN ◯

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ◯ NO ◯

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

CVS Formulary Exception Prior Authorization Form

Formulary Exception/Prior Authorization Request Form

Please return completed form to: 1-888-836-0730

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Patient ID#:				
Address:		Address:		
City:	State:	City:		State:
Home Phone:	Zip:	Office Phone #:	Office Fax #:	Zip:
Gender: M or F	DOB:	Contact Person at Doctor's Office:		

Diagnosis and Medical Information			
Medication:	Strength:		Frequency:
Expected Length of Therapy:	Qty:	Day Supply:	If this is a continuation of therapy, how long has the patient been on the medication?
Diagnosis:		**Diagnosis (ICD) Code(s):**	

FORM CANNOT BE EVALUATED WITHOUT REQUIRED CLINICAL INFORMATION

PLEASE CHECK ALL BOXES THAT APPLY:

☐ Please list **all medications and dates of therapy** the patient has tried specific to the diagnosis and specify below:

Reason for failure, **including date of therapy**, **for each drug**: _____

Drugs contraindicated (Include rationale): _____

Adverse event (e.g. toxicity, allergy) **for each drug**:_____

☐ Is the request for a patient with one or more chronic conditions (e.gl, psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? Specify anticipated significant adverse event: _____

☐ Does that patient have a chronic condition confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____

☐ Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____

☐ Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form: _____

☐ Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____

☐ Other: Please provide additional relevant information: _____

PLEASE COMPLETE CORRESPONDING SECTION ON PAGE 2 FOR THE SPECIFIC DRUG/CLASS LISTED BELOW.

Antifungals/Antiemetic (5-HT3) Agents/Celebrex/Erectile Dysfunction Agents/Insomnia Agents/Proton Pump Inhibitors Provigil/Nuvigil/Stimulants/Tazorac/Tretinoin Products/Testosterone Products/Triptans

****FOR ANY DRUG/CLASS NOT LISTED ON PAGE 2, PLEASE ATTACH RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION****

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: _____

PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

☐ **ANTIFUNGALS: LAMISIL, SPORANOX, PENLAC, DIFLUCAN**

Does the patient have secondary medical risk factors? Please specify which risk factor(s): _____

Does the patient have a diagnosis of Onychomycosis confirmed with a fungal diagnostic test, and does the infection involve the toenails, fingernails or both? **Please circle**

If the diagnosis is Tinea corporis or Tinea cruris, does the patient require systemic therapy or have more extensive superficial infections? **Yes or No**

☐ **ANTIEMETIC (5-HT3) AGENTS:**

Is the patient receiving moderate to highly emetogenic chemotherapy or receiving radiation therapy? **Yes or No**

If the patient has a diagnosis of Hyperemesis Gravidarum, is the patient a documented risk for hospitalization for rehydration? **Yes or No**

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

- vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? **Yes or No**

☐ **CELEBREX:**

Is the patient at risk for a severe NSAID-related gastrointestinal (GI) adverse event (e.g., NSAID associated gastric ulcer, GI bleed)? **Yes or No**

Is the patient being treated for post-operative pain following CABG surgery or have active GI bleeding? **Yes or No**

Has the patient received a 30 days supply of an anticoagulant, antiplatelet, an oral corticosteroid or a gastrointestinal medication? **Yes or No**

Has the patient had intolerance to or an inadequate treatment response to a traditional NSAID or NSAID/GI combination product? **Yes or No**

Is the drug being prescribed for osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, acute pain , primary dysmenorrheal, or juvenile rheumatoid arthritis? **Please circle**

☐ **ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL**

Does the patient require nitrate therapy on a regular OR on an intermittent basis? **Yes or No**

Is it being prescribed for erectile dysfunction ?, **Yes or No** Is the patient using other pharmacological treatments for erectile dysfunction? **Yes or No**

Is the drug being prescribed for Pulmonary Arterial Hypertension (PAH)? **Yes or No**

Is the drug being prescribed for symptomatic Benign Prostatic Hyperplasia (BPH)? **Yes or No**

☐ **INSOMNIA AGENTS:**

Have other treatable medical/psychological causes of chronic insomnia been considered and/or addressed? **Yes or No**

Have appropriate sleep hygiene and sleep environment issues been addressed? **Yes or No**

☐ **PROTON PUMP INHIBITORS:**

Does the patient have frequent and severe symptoms of chronic GERD (e.g., heartburn, regurgitation)? **Yes or No**

Does the patient have atypical symptoms or complications of GERD (e.g., dysphagia, hoarseness, erosive esophagitis)? **Yes or No**

Were the symptoms inadequately controlled with the histamine2-receptor antagonist (H2RA)? **Yes or No**

Is the patient at high risk for GI adverse events? **Yes or No If Yes, why**_____

☐ **PROVIGIL/NUVIGIL:**

Does the patient have a diagnosis of Shift Work Sleep Disorder AND experience excessive sleepiness while working? **Yes or No**

Does the patient have a diagnosis of Obstructive Sleep Apnea confirmed by polysomnography? **Yes or No**

Is the patient currently using continuous positive airway pressure (CPAP) therapy OR is CPAP therapy contraindicated or ineffective for the patient? **Yes or No**

Does the patient have a diagnosis of Narcolepsy, and if so, has the diagnosis been confirmed by sleep lab evaluation? **Yes or No**

☐ **STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA**

Will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior? **Yes or No**

Does the patient have a diagnosis of ADHD or ADD? **Yes or No**

Does the patient have a diagnosis of Narcolepsy, and if so, has the diagnosis been confirmed by sleep lab evaluation? **Yes or No**

☐ **TAZORAC/ TRETINOIN PRODUCTS:**

Does the patient have a diagnosis of Acne Vulgaris or Keratosis Follicularis (Darier's disease, Darier-White disease)? **Yes or No**

Has the patient tried and failed products from the following categories: Salicylic Acid Products OR Benzoyl Peroxide products? **Yes or No**

If the patient is female, has the physician discussed with the patient the potential risks of fetal harm and importance of birth control while using Tazorac? **Yes or No**

Has the pregnancy status of the patient been evaluated? **Yes or No**

Will the patient be applying Tazorac to less than 20 percent of body surface area? **Yes or No**

☐ **TESTOSTERONE PRODUCTS:**

Is the patient being treated for Hypogonadism? **Yes or No**

Did the patient have or does the patient currently have confirmed low testosterone level according to your standard lab reference values? **Yes or No**

☐ **TRIPTANS:**

Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease, or uncontrolled hypertension? **Yes or No**

Does the patient have a diagnosis of migraine headache? **Yes or No** Does the patient have a diagnosis of cluster headache? **Yes or No**

Is the patient currently using migraine prophylactic therapy or unable to take prophylactic therapy due to inadequate response, intolerance or contraindication? **Yes or No**

Has medication overuse headache been considered and ruled out? **Yes or No**

Independent Review Process Application

PROVIDER AND INSURER APPLICATION
NEW YORK STATE INDEPENDENT DISPUTE RESOLUTION FOR EMERGENCY SERVICES AND SURPRISE BILLS

A provider or HMO/insurer (health plan) may dispute a payment or charge for emergency services or a surprise bill. Applicants must: (1) visit the Department of Financial Services (DFS) website at www.dfs.ny.gov to receive a file number; (2) complete this application; and (3) send it to the assigned independent dispute resolution entity. For help call 1-800-342-3736 or e-mail IDRquestions@dfs.ny.gov.

TO BE COMPLETED BY ALL APPLICANTS

1. **File Number assigned by the DFS website:** _____
2. **Applicant Name:**_____
   [ ] Provider [ ] Health plan (Please check one.)
3. **Patient Name:** _____
4. **Patient Address:** _____

   _____
5. **Health Plan:** _____
6. **Health Plan Address:** _____
7. **Phone Number: (_____)**_____**Fax Number: (_____)**_____
8. **Provider Name:** _____
9. **Provider Address:** _____
10. **Phone Number: (_____)**_____**Fax Number: (_____)**_____
11. **Email Address:** _____
12. **What type of payment or charge are you disputing?** (Please check one.)
    [ ] Emergency Services [ ] Surprise Bill for Other than Emergency Services
13. **Date(s) of Service**: _____
14. **Place of Service:** _____
15. **The fee charged by the provider (and include a copy of the bill):** _____
16. **The fee paid to the provider:** _____
17. **The circumstances and complexity of the service including time and place, or submit when contacted by the IDRE if you want considered:** _____

    _____

    _____
18. **Individual patient characteristics, or submit when contacted by the IDRE if you want considered:**

    _____

19. **Independent Dispute Resolution Eligibility:**

    a) **For Emergency Services**: CPT codes 99281 – 99285, 99288, 99291 – 99292, 99217 – 99220, 99224 – 99226, and 99234 – 99236 are not subject to IDR if the bill does not exceed 120% of UCR and the fee disputed is $613.50 (adjusted annually for inflation rates) or less.
    [ ] Yes eligible [ ] Not eligible [ ] Don't know (Please check one.)

    b) **For Surprise Bills:** Have you obtained an assignment of benefits signed by the patient?
    [ ] Yes [ ] No (Please check one.) (If yes, please attach.)

20. **Provider applicants, complete the following or submit when contacted by the IDRE:**

    a) **Include a representative sample of at least 3 fees received by the provider in the last 24 months for the same service, in the same region, from health plans in which the provider does not participate.**

    _____

    b) **The provider's level of training, education and experience in relation to the service.**

    _____

    c) **The provider's usual charge for similar services when the provider does not participate with the health plan.**
    _____

21. **Health plan applicants, complete the following or submit when contacted by the IDRE:**

    a) **A representative sample of at least 3 fees paid by the health plan as a final payment in the last 24 months to non-participating physicians who are similarly qualified for the same service in the same region.**

    _____

    b) **The usual and customary cost for the service and the database from which this was derived.**

    _____

22. **To be completed by all applicants.**
    I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree to pay the IDR fee in full within 30 days from the date of the decision if I am the non-prevailing party. If there is a settlement, I agree to pay half of the prorated fee. If I am the applicant and do not provide information for the IDRE to determine eligibility, the application will be rejected and I agree to pay a processing fee. If I am a provider and the dispute is for a surprise bill, I agree I shall not bill the patient except for any applicable copayment, coinsurance or deductible that would be owed if the patient had utilized a participating provider.

Provider or Health Plan Signature: _____

Print Name: _____

Date: _____

Non-Formulary Marketplace Exception Form

12/3/2014

Prior Authorization Form

OSCAR HEALTHCARE NY EXCHANGE

Non-Formulary Marketplace Exception (HMF)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-855-245-2134**.

Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Non-Formulary Marketplace Exception (HMF).

Drug Name (select from list of drugs shown)

Other, Please specify

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AFHS, Micromedex, current accepted guidelines)? Y N

2. Is the request for a formulary medication for more than the initial quantity limit? Y N

   [If the answer to this question is yes, then skip to question 6.]

3. Is the patient unable to take the preferred formulary alternatives for the given diagnosis due to inadequate treatment response, intolerance, or contraindication? (Requirement: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative). If yes, documentation is required for approval. Provide documentation including name of medication(s) tried, dates of trial(s) and reason for treatment failure(s), intolerance and/or contraindication whichever are applicable. Y N _____

[If the answer to this question is yes, then skip to question 6.]

4. Does the patient have a clinical condition for which there is no formulary alternative or the listed formulary alternatives are not recommended based on published guidelines or clinical literature? If yes, documentation is required for approval. Provide documentation including the clinical condition. Y N

[If the answer to this question is yes, then skip to question 6.]

5. Does the patient require use of a specific dosage form that is not available in the formulary alternatives (examples: suspension, solution, injection)? Y N

6. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Micromedex, current accepted guidelines)? If yes, documentation is required for approval. Provide documentation including name of medication, quantity, strength, directions, and duration requested. Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date

Member Grievance Form

oscar

OSCAR GRIEVANCE FORM - NEW YORK

In order to file a written grievance, the following form should be completed. To file a grievance, please complete all information within this form and mail the completed form to Oscar at the following address: Oscar Insurance, Attention Grievances PO Box 52146, Phoenix AZ, 85072. We will send a response to your grievance within 30 calendar days from the date we receive it.

1. Member Information

Member Name: _____ Date of Birth _____

Member ID #: _____

Home Address: _____

Home Phone Number: _____

2. Please provide a summary of your complaint. Includes dates, any amounts paid and to whom, the names of any providers involved and the types of services that were (or weren't provided). You may attach additional pages if needed.

oscar

3. Did you speak with an Oscar representative about this issue?

___NO ___YES - If yes, please provide the name of the individual that you spoke to and the date:

_____ (name of the rep)

_____ (date)

I acknowledge that the information contained within this form is accurate to the best of my knowledge. I have provided complete and accurate information upon which to base an investigation of the circumstances surrounding the issue. I agree to cooperate and provide any additional information necessary and/or appropriate related to this grievance. My failure to do so may result in Oscar closing the investigation related to this matter.

Signature of Member _____ Date _____

Notice of Non-Discrimination: Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oscar does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oscar:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-855-OSCAR-55 (TTY: 7-1-1).

If you believe that Oscar has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

NY/NJ/TX Members: Oscar Insurance, Attention Grievances PO Box 52146, Phoenix AZ, 85072

CA Members: Oscar Health Plan of California, Attention Grievances 3535 Hayden Avenue, Suite 230, Culver City, CA 90232

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal. hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C.
20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for the Deaf or Hard of Hearing

ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call 1-855-Oscar-55 and dial 711 to receive TTY/TDD services.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Oscar, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-855-OSCAR-55.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Oscar، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أية تكلفة. للتحدث مع مترجم، اتصل بالرقم 1-855-OSCAR-55.

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Oscar մասին, Դուք իրավունք ունեք ստանալ անվճար օգնություն և տեղեկություն Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 1-855-OSCAR-55

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, Oscar, সম্পর্কে প্রশ্ন আছে আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন ১-৮৫৫-অস্কার-৫৫.

如果您，或是您正在協助的對象，有關於 Oscar 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-855-OSCAR-55。

اگر شما، یا فردی که شما به او کمک مي کنيد ، سوالی در مورد Oscar داشته باشيد، حق اين را داريد که کمک و اطلاعات به زبان خود را به طور رايگان دريافت نماييد. لطفا با شماره 1-855-OSCAR-55 تماس بگيريد.

Si vous, ou une personne que vous aidez, a des questions à propos d'Oscar, vous avez le droit d'obtenir de l'aide et des informations dans votre langue gratuitement. Pour parler à un interprète, appelez le 1-855-OSCAR-55.

Falls Sie oder jemand, dem Sie helfen, Fragen zu Oscar haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-855-OSCAR-55 an.

Εάν εσείς ή κάποιος που βοηθάτε έχετε απορίες σχετικά με την Oscar, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς καμία χρέωση. Για να μιλήσετε με έναν διερμηνέα, καλέστε στον αριθμό 1-855-OSCAR-55.

જો તમે અથવા તમે મદદ કરી રહ્યા હો તેમાથી કોઈને Oscar વિશે પ્રશ્નો હોય તો, તમને તમારી ભાષામાં નિશૂલ્ક મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-855-OSCAR-55 પર ફોન કરો.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Oscar, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-855-OSCAR-55.

यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के पास Oscar के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दोभाषिए से बात करने के लिए, 1-855-OSCAR-55 पर कॉल करें।

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Oscar, koj muaj cai kom lawv muab cov ntsiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-855-OSCAR-55.

Se tu o qualcuno che stai aiutando avete domande su Oscar, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-OSCAR-55.

貴殿または貴殿の援助されている方でも、Oscarについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話をされる場合、1-855-OSCAR-55までお電話ください。

ប្រសិនបើលោកអ្នក ឬនរណាម្នាក់ដែលលោកអ្នកកំពុងជួយ មានសំណួរនានាអំពី Oscar លោកអ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសារបស់លោកអ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខ 1-855-OSCAR-55 ។

귀하 또는 귀하가 돕고 있는 사람이 Oscar에 관해서 문의사항이 있는 경우, 귀하에게는 이러한 도움과 정보를 귀하의 언어로 비용 부담없이 제공받을 권리가 있습니다. 통역 서비스를 원하시면 1-855-OSCAR-55번으로 전화해 주십시오.

ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອຢູ່ມີຄຳຖາມກ່ຽວກັບ Oscar, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໃຫ້ໂທຫາ 1-855-OSCAR-55.

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Oscar, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-855-OSCAR-55.

ਜੇ ਤੁਹਾਡੇ ਕੋਲ, ਜਾਂ ਤੁਸੀ ਜਿਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Oscar ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਸਿ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਵਚਿ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Oscar, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-OSCAR-55.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Oscar, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-OSCAR-55.

Kung ikaw o ang iyong tinutulungan ay may mga tanong tungkol sa Oscar, may karapatan kang makatanggap ng libreng tulong at impormasyon nang nasa iyong wika. Upang makipag-usap sa isang tagasalin, tumawag sa 1-855-OSCAR-55.

หากคุณหรือคนที่คุณก าลังช่วยเหลือมีค าถามเกี่ยวกับ Oscar
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-855-OSCAR-55.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про програму OSCAR, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть за номером 1-855-OSCAR-55.

اگر آپ یا آپ کسی کی مدد کر رہے /رہی ہیں ان کو Oscar کے بارے سوالات پوچھنے ہیں ، تو آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے 1-855-OSCAR-55 پر کال کریں۔

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Oscar, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-OSCAR-55.

אויב איר, אודר עמצער איר העלפסט, האט פראגעס וועגן Oscar, איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך אומזיסט. צו רעדן מיט דער אייבערשטער, קלונג 1-855-OSCAR-55

PQI Referral Form

Potential Quality Issue (PQI) Referral Form

DIRECTIONS: To report a potential quality issue, fax to Quality Improvement 888.732.0625

Member Information			
Member First and Last Name:		*Date of Birth (mm/dd/yyyy)*	
Member ID # if available:		*Gender:*	
Provider Information			
Provider (facility) or Practitioner of Concern (if applicable):			
Contracted ☐ Non-Contracted ☐ Unsure		*contracted, indicate Facility/Provider ID #*	
Facility or Location Where Care Was Rendered			
PQI Indicator Category (check all that apply)			
☐ Access and/or availability ☐ Assessment/Treatment/Diagnosis ☐ Communications/Conduct ☐ Continuity of Care ☐ Other		☐ Pharmacy/UM Authorization ☐ Readmission/UM ☐ Safety ☐ Surgical Services ☐ Unexpected Death	
Date of PQI Occurrence:	_____/_____/_____	Date PQI Identified:	_____/_____/_____
Describe Incident or Concern (Please be as specific as possible, include witnesses if applicable)			
Reported by (Optional):			
Name/Title:		Phone #:	
Organization:		Date Submitted:	

Provider Dispute Resolution Form

Provider Dispute Resolution Form

*Disputes must be filed within **365 days** of the last date of decision or communication by Oscar*

If you have not previously addressed this issue with Oscar, please call 855-OSCAR-55 to speak with a representative. This matter should undergo a preliminary review before filing a dispute.

Filling out this completed form will constitute a provider initiating a formal Dispute with Oscar and will trigger Oscar's Dispute Resolution Process

- Please complete this form (all fields with * are required), and mail to:
  Oscar Insurance Corporation
  PO Box 278
  New York, NY 10013
- You can also fax this form to: **888-977-2062**
- Please call Oscar at **855-OSCAR-55** if you want to check on the status of your Dispute

1. Provider Information

*Provider Name: _____ *Provider NPI: _____

*Provider Tax ID Number: _____

*Provider Address: _____

*Phone: _____ Fax: _____ Email: _____

***Provider Type** (please check box):

❑ Physician ❑ Ancillary ❑ Hospital ❑ Ambulatory Surgical Center ❑ Skilled/General Nursing Facility

❑ Durable Medical Equipment ❑ Rehabilitation Center ❑ Home Health ❑ Ambulance

❑ Assisted Living Facility ❑ Other (please specify): _____

2. Dispute Information

***Dispute Type** (please check box):

❑ Contracted Rate ❑ Timely Filing ❑ Out-of-network review ❑ Benefits decision ❑ Claims messages ❑ Health plan refund request ❑ Prompt Payment ❑ Request for additional information

❑ Other (please specify): _____

Provider Dispute Resolution Form

*Disputes must be filed within **365 days** of the last date of decision or communication by Oscar*

Disputed Claim Information

If there are multiple claims being disputed please use template spreadsheet labeled "Multiple Claims Sheet"

*Patient Name: _____

*Patient's Oscar ID number: _____

*Claim ID: _____

*Date(s) of Service: _____

Dispute Description

❑ Check here if supporting documentation is enclosed

Please be specific and include how you would like this to be resolved:

UB-04 Claim Form

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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19									19
20									20
21									21
22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

Appendix

Member ID Card

Guide to the Independent Review Process

oscar

Emergency Services & Surprise Bills –
Independent Dispute Resolution Process

Beginning on April 1, 2015, the New York State "Emergency Services Surprise Bill Law" goes into effect which protects patients from "surprise" out-of-network bills. You can read more about the regulation here: http://www.dfs.ny.gov/consumer/hprotection.htm

Patients, providers, and health plans like Oscar now have access to an Independent Dispute Resolution (IDR) process by which an independent third party (Independent Dispute Resolution Entity or IDRE) helps health plans and providers negotiate and settle appropriate charges on these "surprise" bills.

For members who wish to raise a dispute, Oscar or your provider must file the IDR application on your behalf. We provide instructions below on how to proceed if you would like Oscar to file the application for you.

	How to submit a dispute to an IDRE	**Required forms (& link for download)**
Members	• Contact Oscar via email, phone, or fax with information from the bill you would like to dispute • Submit Assignment of Benefits form to Oscar as instructed (email to NY-IDRE@hioscar.com or fax (888) 977-2062) • Oscar will submit an IDR application and may enter into negotiation with the provider on your behalf	Assignment of benefits (send to Oscar)
Providers	Submit the IDR application directly to DFS (or contact Oscar to initiate the process)	IDR Application

If you have any questions, please don't hesitate to reach out to us at 855-OSCAR-55. We'll help you figure out your bill and any steps you should be taking.

Privacy and Confidentiality Practices

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Notice of Privacy Practices

Effective October 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Oscar Insurance Corporation, Oscar Insurance Corporation of New Jersey, Oscar Insurance Company of Texas and Oscar Health Plan of California, (collectively, "Oscar") are licensed insurance companies or health plans respectively in New York, New Jersey, Texas and California.

In order to provide services, Oscar may provide information to other vendors, entities etc. in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"). Oscar will comply with all applicable privacy laws and respect the confidentiality of your health information. The following notice, which is required by law, explains how Oscar uses information about you and when we can share that information with others. Oscar has the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide you with a revised notice by direct mail or electronically as permitted by applicable law. In all cases, Oscar will post the revised notice on our website.

The following notice informs you about your rights with respect to your health information and how you can exercise these rights.

Oscar collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our members. Oscar uses security safeguards and techniques designed to protect your health information. We train our employees about our privacy policies and practices, and we limit access to your information to only those employees who need it in order to perform their business responsibilities. Oscar does not sell information about our customers or former customers.

HOW OSCAR USES OR DISCLOSES YOUR INFORMATION

Oscar may use or share information about you for purposes of payment, treatment and health care operations, including with our business associates. For example:

- **Payment:** Oscar may use your information to process and pay claims submitted to us by you or your doctors, hospitals and other health care providers in connection with medical services provided to you.
- **Treatment:** Oscar may share your information with your doctors, hospitals, or other providers to help them provide medical care to you. For example, if you are in the hospital, we may give the hospital access to any medical records sent to us by your doctor(s).
- **Health Care Operations:** Oscar may use and share your information in connection with our health care operations. These include, but are not limited to:

performing coordination of care and case management, speaking with your provider to suggest a disease management or wellness program to improve your health, providing you with information about alternative medical treatments or health related services that may interest you, conducting medical reviews or audits, and/or performing general administrative activities such as customer service.

Oscar may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** Oscar may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** Oscar may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member (when you are incapacitated or in an emergency), or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest.

- **For Public Health Activities** such as reporting or preventing disease outbreaks.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

- **For Law Enforcement Purposes.** Oscar may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

- **To Provide Information Regarding Decedents**. Oscar may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

- **For Organ Procurement Purposes.** Oscar may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Oscar's business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or

disclose any information other than as specified in our contract.

- **For Data Breach Notification Purposes**. Oscar may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information to you or another party. We will notify you in the event your information is disclosed in a manner that does not comply with HIPAA.

- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - HIV/AIDS;
    - Mental health;
    - Genetic tests;
    - Alcohol and drug abuse;
    - Sexually transmitted diseases and reproductive health information; and
    - Child or adult abuse or neglect, including sexual assault.

  If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Except for uses and disclosures described and limited as set forth in this notice, Oscar will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at anytime in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, you may call Oscar at 800-766-8746.

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Please note that while Oscar will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different address. Oscar will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. Oscar will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to Oscar at 295 Lafayette Street, 6th Floor, NY, NY 10012.

- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to Oscar's Privacy Office at 295 Lafayette Street, 6th Floor, NY, NY 10012. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, you will have the right to request that we send a

copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.

- **You have the right to ask to amend** information Oscar maintains about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to Oscar's Privacy Office at 295 Lafayette Street, 6th Floor, NY, NY 10012. If Oscar denies your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may also obtain a copy of this notice at www.hioscar.com.

EXERCISING YOUR RIGHTS

- **Contacting Oscar.** If you have any questions about this notice or want to exercise any of your rights, you may contact Oscar at 800-766-8746.

- **Submitting a Written Request.** You can mail your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, to: Oscar, 295 Lafayette Street, 6th Floor, NY, NY 10012.

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at Oscar's Privacy Officer at 295 Lafayette Street, 6th Floor, NY, NY 10012. **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective October 1, 2013, Oscar is committed to maintaining the confidentiality of your personal financial information. For the purpose of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information Oscar Collects

Oscar collects personal financial information about you from sources such as applications, claims forms, consumer reports and other transactional documents. These documents may contain information such as your name, address, age, medical information, and/or social security number.

Disclosure of Information - Restrictions

- Oscar does not disclose genetic information for underwriting purposes.

- Oscar does not sell any member information without the express written authorization of the member; this specifically includes for marketing purposes.

- Oscar does not disclose personal financial information about our members or former members to any third party, except as required or permitted by law. For example, in the course of our general business practices, Oscar may, as permitted by law, disclose any of the personal financial information that we collect about you, without your

authorization, to the following types of institutions:

- To Oscar's corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;

- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and

- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Questions About this Notice

If you have any questions about this notice, please contact Oscar at 855-OSCAR-55.

Surprise Bills and How to Submit a Claim

Surprise Bills

A surprise bill is when:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician;

OR

2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by Oscar. A referral to a non-participating provider occurs when: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen, such as blood work, from you in the office and sends it to a non-participating laboratory or pathologist.

How to submit a surprise bill

If you have received a service from an out-of-network provider, you received a bill for those services and you did not know that the provider was not in the OSCAR network, your claim may qualify as a 'surprise bill'.

In this case, submit a benefit assignment form to us at help@hioscar.com and ask your provider to submit a claim to Oscar (Electronic Payer ID 11303 or to MagnaCare, PO BOX 1001, Garden City, NY 11530).

We will review your situation and get back to you as soon as we can.

We will pay surprise bill claims at 55% of the usual, customary, and reasonable (UCR) charge value for each procedure code. UCR values are the 80th percentile of non-discounted charges as listed in the FAIR Health national benchmark database for the relevant geographic area. On average, the allowed value for the claims that we have paid at Oscar is 51% of UCR. This calculation accounts for all professional claims excluding any office-administered medication.

Reimbursement Policies

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In-Office Laboratory Testing & Procedures

Policy

The In-Office Laboratory Testing and Procedures List is a list of laboratory procedural/testing codes that Oscar will reimburse its Network physicians to perform in their offices. This list represents procedures/tests that Oscar Network physicians can perform in their offices that will be reimbursed by Oscar at a rate similar to the CMS reimbursement for claims. All other lab procedures/tests must be performed by one of the participating laboratories in Oscar's network or reimbursement to the physician's office is reduced to a level near the contractual allowable paid to our contracted laboratories.

In-Office Laboratory Testing and Procedures Code List

Code	Description	Notes
81000	Urinalysis, non-automated, with microscopy	
81001	Urinalysis, automated, with microscopy	
81002	Urinalysis, non-automated, without microscopy	
81003	Urinalysis, automated, without microscopy	
81025	Urine pregnancy test, by visual color comparison methods	
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)	
82271	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources	
82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening	
82948	Glucose; blood, reagent strip	
82962	Glucose, blood sugar by glucometer	
83014	Helicobacter pylori, breath test analysis; drug administration	
83026	Hemoglobin; by copper sulfate method, non-automated	
83655	Lead	
85013	Blood count; spun microhematocrit	
85018	Blood count; hemoglobin (Hgb)	
85651	Sedimentation rate, erythrocyte; non-automated	
86403	Particle agglutination, screen, each antibody	
86485 - 86580	Skin tests; various	

87070	Culture, bacterial; any other source but urine, blood or stool, with isolation and presumptive identification of isolates.	
87081	Culture, bacterial, screening only, for single organisms	
87177	Ova and parasites, direct smears, concentration and identification.	
87210	Smear, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites	
87220	Tissue examination for fungi (e.g., KOH slide)	
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza	
87880	Infectious agent detection by immunoassay-streptococcus group A	
88738	Hemoglobin (Hgb), quantitative, transcutaneous	
89100	Duodenal intubation and aspiration; single specimen plus appropriate test	
89105	Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube	
89130 - 89141	Gastric intubation and aspiration; various	
89350	Sputum, obtaining specimen, aerosol-induced technique	
99195	Phlebotomy, therapeutic (separate procedure)	
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	For Stat Purposes Only
82247	Bilirubin, Total	Pediatricians
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	Dermatologists
88332	Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)	Dermatologists
89060	Crystal Identification by light microscopy with or without polarizing lens analysis; tissue or any body fluid (except urine)	
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	
89310	Semen analysis; motility and count (not including Huhner test)	
89320	Semen analysis; volume, count, motility and differential	
89321	Semen analysis; sperm presence and motility of sperm, if performed morphologic criteria (eg, Kruger)	
89322	Semen analysis; volume, count, motility, and differential using strict	
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)	
85007	Blood count; automated differential WBC count blood smear, microscopic examination with manual differential WBC count	

85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	
85097	Bone marrow; smear interpretation only, with or without differential cell count	
86077	Blood bank physician services; difficult cross-match and/or evaluation of irregular antibody(s), interpretation and written report	
86078	Blood bank physician services; investigation of transfusion reaction, including suspicion of transmissible disease, interpretation and written report	
86079	Blood bank physician services; authorization for deviation from standard blood banking procedures, with written report	
86927 - 86999	Transfusion medicine	
84146	Prolactin	
84443	Thyroid stimulating hormone (TSH)	
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)	
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	Ophthalmologists
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistological study to determine adequacy for diagnosis, first evaluation episode, each site	Endocrinologists
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistological study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)	Endocrinologists

Publication History

Date	Action/Description
9/01/2015	Original Documentation
9/27/2015	Approval and inclusion in Oscar Provider Manual

Obstetrical Care Bundling

Policy

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services. Unless otherwise specified, for the purposes of this policy Same Group Physician and/or Other Health Care Professional includes all physicians and/or other healthcare professionals of the same group reporting the same federal tax identification number.

1) Global Obstetrical Care - Global Obstetrical Care As defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the Same Group Physician and/or Other Health Care Professional provides all components of the OB package, report the global OB package code.

2) Antepartum Care Only - Accommodates for situations such as termination of a pregnancy, relocation of a patient or change to another physician. In these situations, all the routine antepartum care (usually 13 visits) or global (OB) care may not be provided by Same Group Physician and/or Other Health Care Professional.

3) Delivery Services Only - Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.

4) Postpartum Care Only - Includes the postpartum period to be six weeks following the date of the cesarean or vaginal delivery.

5) Delivery + Postpartum Care - Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT book has codes for vaginal and cesarean section deliveries that encompass both of these services. The following are CPT defined delivery plus postpartum care codes:

Obstetric Care Bundles

Code(s)	Description	Code Type
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	Global Obstetric
59510	Routine obstetric care including antepartum care, cesarean delivery and postpartum care	Global Obstetric

59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	Global Obstetric
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.	Global Obstetric
59425	Antepartum care only; 4-6 visits	Antepartum Care Only
59426	Antepartum care only; 7 or more visits	Antepartum Care Only
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	Delivery Services Only
59514	Cesarean delivery only	Delivery Services Only
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	Delivery Services Only
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	Delivery Services Only
59430	Postpartum care only (separate procedure)	Post-Partum Care Only
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	Delivery + Post-Partum
59515	Cesarean delivery only; including postpartum care	Delivery + Post-Partum
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	Delivery + Post-Partum
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care.	Delivery + Post-Partum

Services Included in the "Global Obstetrical" Care Package

Description	Code(s)
All routine prenatal visits until delivery (approximately 13 for uncomplicated cases)	
Initial and subsequent history and physical exams	
Recording of weight, blood pressures and fetal heart tones	
Routine chemical urinalysis	81000, 81002
Admission to the hospital including history and physical	
Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery	
Management of uncomplicated labor	
Delivery of placenta	59414
Administration/induction of intravenous oxytocin	96365 - 96367
Insertion of cervical dilator on same date as delivery	59200
Repair of first or second degree lacerations	

Simple removal of cerclage (not under anesthesia)

Uncomplicated inpatient visits following delivery

Routine outpatient E/M services provided within 6 weeks of delivery

Services Excluded from the "Global Obstetrical" Care Package

The following services are excluded from the global OB package and may be reported separately if warranted:

Description	Code(s)
Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of diagnosis code V72.42 (Pregnancy examination or test, positive result)	
Laboratory tests (excluding routine chemical urinalysis)	
Maternal or fetal echography procedures	76801 - 76828
Amniocentesis, any method	59000, 59001
Amnioinfusion	59070
Chorionic villus sampling (CVS)	59015
Fetal contraction stress test	59020
Fetal non-stress test	59025
External cephalic version	59412
Insertion of cervical dilator more than 24 hours before delivery	59200
E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services.	
Additional E/M visits for complications or high risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.	
Inpatient E/M services provided more than 24 hours before delivery	
Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).	

Services Included in the "Delivery Services Only" Care Package

Description	Code(s)
Admission to the hospital	
The admission history and physical examination	
Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps, with or without vacuum extraction), or cesarean delivery, external and internal fetal monitoring provided by the attending physician	
Intravenous (IV) induction of labor via oxytocin	96365 - 96367
Delivery of the placenta; any method	
Repair of first or second degree lacerations	
Cervical dilator	59200

High Risk/Complications

A patient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global obstetrical codes. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made. Oscar will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

E/M Service with an Obstetrical (OB) Ultrasound Procedure

Oscar follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820- 76828) only if the E/M service has modifier 25 appended to the E/M code. If the patient is having an OB ultrasound and an E/M visit on the same date of service, by the Same Individual Physician or Other Health Care Professional, per ACOG coding guidelines the E/M service may be reported in addition to the OB ultrasound if the visit is identified as distinct and separate from the ultrasound procedure. Per CPT guidelines, modifier 25 should be appended to the E/M service to identify the service as separate and distinct.

Multiple Gestation

Oscar's reimbursement for twin deliveries follows ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries. See table below for appropriate code submission regarding delivery of twin births.

Delivery Type	Baby	Code-Modifier
Vaginal	Baby A	59400
	Baby B	59409-59
VBAC	Baby A	59610
	Baby B	59612-59
Cesarean Delivery	Baby A + Baby B	59510
Repeat Cesarean Delivery	Baby A + Baby B	59518
Vaginal Delivery + Cesarean Delivery	Baby A	59409-51
	Baby B	59510
VBAC + repeat Cesarean Delivery	Baby A	59612-51
	Baby B	59618

Publication History

Date	Action/Description
9/01/2015	Original Documentation
9/27/2015	Approval and inclusion in Oscar Provider Manual

Assistant Surgeon

Policy

An assistant surgeon is considered medically necessary when the complexity of the operation necessitates the primary surgeon have additional skilled operative assistance from: 1) Another surgeon, 2) Licensed Physician Assistant, 3) Registered Nurse First Assistant. Oscar provides coverage for assistant surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

An assistant surgeon is distinguished from an “assistant-in-surgery.” Generally, assistants-in-surgery are non-MD professionals such as nurses, operating room technicians, or other specially trained professionals, whose services are included in the primary surgeon’s, or the facility’s, reimbursement. These services are not separately reimbursed.

There may be times when a physician elects to utilize more than one assistant during the operative session. However, only one assistant per operative session will be reimbursed. Claims for services of an assistant surgeon should be filed with modifier 80, 81, 82 or AS. Use of modifiers is required for proper payment.

Coding

Oscar follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with the following status code indicator "2" for "Assistant Surgeons" are considered by Oscar to be reimbursable for Assistant Surgeon services, as indicated by an Assistant Surgeon modifier (80, 81, 82, or AS).

Assistant Surgeons who are Physicians or non-Physicians should submit the identical procedure code(s) as the primary surgeon with one of the following modifiers to represent their service(s):

Assistant Surgeon Modifiers

Modifier	Description	Type of Professional
80	Assistant Surgeon	Physician
81	Minimum Assistant Surgeon	Physician
82	Assistant Surgeon (when qualified resident surgeon not available)	Physician
AS	PA (physician assistant), nurse practitioner, or clinical nurse specialist services for assistant at surgery	non-Physician*

* Health care professionals acting as Assistant Surgeons should report their services under a surgeon's provider number.

Reimbursement

Oscar's standard reimbursement for qualified Assistant Surgeon services are 16% of the allowable amount when performed by a physician and 14% of the allowable amount when performed by a non-Physician (as defined above). This percentage is based on CMS.

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Initial Policy Approval

Co-Surgeons / Team Surgeons

Policy

The use of multiple surgeons for a single procedure is considered medically necessary when the nature and/or complexity of the procedure necessitates contribution and expertise from more than one surgeon. Oscar provides coverage for multiple surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

Coding

Oscar follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered by Oscar to be eligible for Co-Surgeon services as indicated by the co-surgeon modifier 62. All codes in the NPFS with the status code indicators "1" or "2" for "Team Surgeons" are considered by Oscar to be eligible for Team Surgeon services as indicated by the team surgeon modifier 66. Use of modifiers is required for proper payment.

Co-Surgeon & Team Surgeon Modifiers

Modifier	Description	Type of Professional
62	Two Surgeons	Physician *
66	Team Surgeons	Physician

* Physicians acting in the more limited capacity of an 'Assistant Surgeon' should bill with modifiers 80 or 82 and are not eligible for Co-Surgeon reimbursement

Reimbursement

Co-Surgeons

Each co-surgeon should submit the same Current Procedural Terminology (CPT) code with modifier 62. Consistent with CMS guidelines, Oscar will reimburse co-surgeon services at 62.5% of the allowable amount to each surgeon subject to additional multiple procedure reductions if applicable. The allowable amount is determined independently for each surgeon and is the amount that would be given to that surgeon performing the surgery without a co-surgeon.

Team Surgeons

Each Team Surgeon should submit the same CPT code with modifier 66 along with written medical documentation describing the specific surgeon's involvement in the total procedure. Oscar will review each submission with its appropriate medical documentation and will make reimbursement decisions on a case-by-case basis.

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Initial Policy Approval

Non-Reimbursable Services

Policy

Consistent with guidelines specified by the Centers for Medicare and Medicaid Services (CMS), Oscar does not reimburse for the procedures or categories of codes outlined in this policy. This list is not all-inclusive. Denials include non-covered services defined as exclusions in the member's evidence of coverage (EOC), payment included in the allowance of another service (i.e., global) and procedure codes submitted that are not eligible for payment.

Coding

Category II CPT Codes (XXXXF)

These codes are intended to facilitate data collection about quality of care. Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes.

Category III CPT Codes (XXXXT)

Temporary codes for emerging technology, services and procedures. Services should be resubmitted with an unlisted code. Supporting documentation is required with the claim.

Bundled Services/Supplies (Status "B" or "T" Procedure)

Codes identified with a CMS indicator of "B" or "T" (bundled code) in the CMS NPFS (National Physician Fee Schedule) will not be separately reimbursed to physicians by Oscar. Payments for these procedures are always bundled into payment for other services and separate payment is never made.

PC/TC Indicator 5 Codes

Oscar denies "Incident To" codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual

Anesthesia

Policy

Oscar Insurance reimburses anesthesia based on the concepts of basic values, time unit values, and conversion factors. Basic values are defined by the ASA and time units are calculated on a 15 minute interval basis and rounded to the nearest decimal point (e.g. 32 minutes of anesthesia equals 2.1 time units). Conversion factors are either explicitly listed in provider contracts or based on CMS localities. Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under postoperative supervision.

The following formula is used to determine anesthesia reimbursement:

(Base Value + Time Units) x Conversion Factor = Reimbursement

Physical status modifiers and qualifying circumstances are taken into account when calculating time unit values. The following modifiers should be included when appropriate:

Physical Status Modifier	Description	Time Unit Adjustments
P1	A normal healthy person	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant life threat	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain dead patient whose organs are being removed for donor purposes	0

Qualifying Circumstance	Description	Time Unit Adjustments
99100	Anesthesia for patients of extreme age, under 1 year and over 70	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions (specify)	2

In addition to the above modifiers and codes, the following modifiers should also be applied to distinguish when services are not directly performed by an anesthesiologist:

Type of Provider	Code	Description	Payment
Anesthesiologist	AA	Anesthesia services performed personally by an anesthesiologist	100% of fee schedule based on appropriate unit rate
	AD	Medical supervision for more than four concurrent anesthesia procedures is provided	Reimbursed at a rate equal to three base value units
	GC	Services performed in part by a resident under the direction of a teaching physician	Services are reimbursable at 100% of the allowable when billed by the teaching anesthesiologist. (Note: the teaching anesthesiologist must bill with the “AA” modifier in the first field and the “GC” certification modifier in the second field.)
	QK	Medical direction of two, three or four concurrent anesthetic procedures involving qualified individuals (e.g., CRNAs or residents)	Allows 50% of fee schedule payment based on the appropriate unit rate
	QY	Anesthesiologist medically directed one CRNA	Allows 50% of fee schedule payment based on the appropriate unit rate
CRNA	QZ	CRNA performed services without medical direction	100% of fee schedule based on appropriate unit rate
	QX	CRNA performed services under the medical direction of an anesthesiologist	Allows 50% of fee schedule payment based on the appropriate unit rate

There are also a few additional cases that require more specific pricing. These include:

- Reimbursement for neuraxial/epidural labor is based on the actual time unit capped at the following minutes:
  - Vaginal delivery codes are capped at a total of 225 minutes/15 time units
  - Cesarean section delivery codes are capped at a total of 270 minutes/18 time units

Publication History

Date	Action/Description
09/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual
3/07/2016	Update

Hospital Based Clinics

Policy

Oscar reimburses professional providers for covered services provided in a facility clinic setting when reported on a professional CMS 1500 form with a place of service office. This reimbursement includes both the professional services and the associated overhead. Oscar will not separately reimburse a facility for facility clinic visits and services billed on a UB-04 when reported with revenue codes 510-519, 520-529 and any successor codes.

The technical and overhead component of the facility clinic visit is included in the benefit paid to the professional provider for professional services, which encompasses but is not limited to E&M services in a clinic setting. The facility may not seek reimbursement for any technical or overhead component of the clinic charge from Oscar or the member. The member is held harmless for these clinic overhead charges.

Coding

Codes	Description	Comment
510 - 519	Clinics	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied.
520 - 529	Free Standing Clinics	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied.
960-969	Professional Fees - Clinics	Bill with appropriate E&M codes
G0463	Hospital Outpatient clinic visit for assessment and management of a patient	Not reimbursed

Publication History

Date	Action/Description
11/11/2015	Original Documentation
12/01/2015	Approval and inclusion in Oscar Provider Manual

Bilateral Procedures

Reimbursement Policies

Policy

Bilateral procedures are procedures performed on both sides of the body during the same encounter or on the same day. Oscar follows the bilateral procedure CMS standards in the NPFS (National Physician Fee Schedule) for adjustment of payment.

Bilateral services must be billed on a single line with modifier -50 appended. Modifier -50 is not applicable to procedures that are bilateral by definition or procedures with descriptions that include such terminology as “bilateral” or “unilateral.” Do not use Modifiers RT and LT when modifier -50 applies.

Reimbursement

Procedure Eligible for Bilateral Payment Adjustment

Status Indicator 1:
If the procedure is billed with the -50 bilateral modifier, a 150% payment adjustment applies.

Status Indicator 3:
Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures with CMS status indicator 1. If a procedure is reported with modifier -50, payment is based on 100% of the standard reimbursement for each side.

Procedures Ineligible for Bilateral Payment Adjustment

Status Indicator 2:
Payment for these services is already considered bilateral. If the procedure is submitted with modifier -50 or reported twice, payment is still 100% of the standard reimbursement.

Publication History

Date	Action/Description
10/09/2015	Original Documentation
11/01/2015	Initial Policy Approval

Multiple Procedures

Policy

When multiple procedures are performed on the same day, by the same group, physician, or other healthcare professional, reduction in reimbursement for secondary and subsequent procedures will occur. Oscar follows the multiple procedure CMS standards for reduction of payment. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

Reimbursement

Surgical / Endoscopic Procedures (Status Indicators 2 & 3)

If a procedure is reported on the same day as another procedure with an indicator of 2 or 3, the procedures with the greatest reimbursable amount will be paid at 100% followed by 50% for all subsequent procedures. Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

Special rules for multiple endoscopic procedures apply if an endoscopic procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of the CMS NPFS Relative Value File. The multiple endoscopy rules are applied to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

Imaging / Radiology (Status Indicator = 4)

If a diagnostic imaging procedure is billed with, or reported in the same session on the same day, as another diagnostic imaging subject to a multiple imaging reduction (services with an '88' diagnostic imaging family indicator), Oscar pays 100% of the technical component for the highest priced procedure, and 50% for the technical component of each subsequent procedure. Oscar does not follow the CMS standard of a 25% reduction in the professional component and are always paid at 100%.

Cardiovascular Services (Status Indicator = 6)

For cardiovascular services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group

practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

Ophthalmology Services (Status Indicator = 7)

For ophthalmology services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

Global / Case Rate Adjustment

When a procedure requires a multiple procedure reduction but is billed as a global / case-rated procedure, Oscar will apply an appropriate technical component reduction on a fixed 60% of the total payable amount. If a professional component payment reduction is appropriate, it is applied on a fixed 40% of the total payable amount.

Sources

CMS Transmittal 995 (11/04/2011): https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R995OTN.pdf

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/01/2015	Initial Policy Approval

Unlisted and Unspecified Procedures

Policy

Unlisted procedure codes are used when the services performed do not have specific codes assigned to them. When submitting claims with such unlisted or unspecified procedures, it is necessary to attach supporting documentation describing the services that were performed. Such documentation should include the following information:

- A clear description of the nature, extent, and need for the procedure or service;
- Whether the procedure was performed independently of other services provided, or if it was performed at the same surgical site or through the same surgical opening;
- Any extenuating circumstances which may have complicated the service or procedure;
- Time, effort, and equipment necessary to provide the service; and
- The number of times the service was provided.

When submitting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure code.

Reimbursement

Claims submitted with unlisted procedure codes and without supporting documentation will be denied. No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code. When performing two or more procedures that require the use of the same unlisted CPT code, the unlisted code should only be reported once to identify the services provided (excludes unlisted HCPCS codes; for example, DME/ unlisted drugs). Unlisted codes for DME, orthotics, and prosthetics require appropriate NU, RR or MS modifier in order to be considered for reimbursement. All other unlisted procedure codes appended with a modifier will be denied.

Required Documentation

Procedure Code Category	Documentation Requirements
Surgical procedures: all unlisted codes within the range of 10021–69990	Operative or procedure report
Radiology/imaging procedures: all unlisted codes within the range of 70010–79999	Imaging report
Laboratory and pathology procedures: all unlisted codes within the range of 80047–89398	Laboratory or pathology report
Medical procedures: all unlisted codes within the range of 90281–99607	Office notes and reports

Unlisted HCPCS procedure codes	Operative or procedure report
Unclassified drug codes	NDC Number with full description/name and strength of the drug
Unlisted HCPCS DME codes	Provide narrative on the claim

Publication History

Date	Action/Description
10/09/2015	Original Documentation
11/01/2015	Initial Policy Approval

Medically Unlikely, Mutually Exclusive, and Component Procedures

Policy

Oscar reimburses providers for services that are medically appropriate and adhere to CMS standard coding conventions. Oscar follows Medicare National Correct Coding Initiative (NCCI) standards for not reimbursing services that are mutually exclusive, medically unlikely, or component services reported alongside more comprehensive procedures.

Reimbursement

Mutually Exclusive Procedures

Mutually exclusive procedures are codes that cannot reasonably be done at the same anatomic site, during the same patient encounter, or the coding combination represents two methods of performing the same service. An example of mutually exclusive procedures is the repair of an organ, performed by two different methods since only one method can be chosen to repair the organ. Mutually exclusive coding combinations are considered submitted in error and only one of the services will be reimbursed. The Medicare National Correct Coding Initiative (NCCI) has published procedure-to-procedure (PTP) claims edits that prevent inappropriate payment in these scenarios. Oscar adopts these claims edits and will not reimburse providers for mutually exclusive procedures.

Medically Unlikely Procedures

Medically unlikely procedures are codes that are anatomically or clinically limited with regard to the number of times they may be performed on a single day. In addition to the PTP edits, NCCI has published medically unlikely claims edits (MUEs) that prevent payment for an inappropriate number or quantity of the same service on a given day. Oscar adopts these claims edits and will not reimburse providers for services flagged as medically unlikely.

Comprehensive and Component Procedures

NCCI's PTP edits also address component and comprehensive procedures. Services that are integral to another service are component parts of the more comprehensive procedure. The PTP edits prevent payment for component services reported alongside comprehensive services. Oscar adopts these claims edits and will not separately reimburse providers for component services if reported alongside comprehensive services.

Publication History

Date	Action/Description

10/09/2015	Original Documentation
11/01/2015	Initial Policy Approval

Observation Stays

Reimbursement Policy

Policy

An Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours, and the need for an inpatient admission can be determined within this specific period. Oscar separately reimburses observation services performed in an Oscar-contracted facility only under specific circumstances.

Prior Authorization

- Observation stays that are discharged within the 48 hour time window do not require prior authorization and can be billed as outpatient.
- If an observation stay is to exceed 48 hours, follow prior authorization guidelines listed below in the inpatient admission section.

Reimbursement

Inpatient Admission Following Observation Stay

- If an observation stay is within 48 hours and followed by an inpatient admission, the observation stay should be billed separately as an outpatient service and is not subject to prior authorization. The inpatient stay requires prior authorization and should be billed separately.
- If an observation stay exceeds 48 hours, it should be billed as an inpatient stay and will be subject to prior authorization.

Emergency Department Services Preceding Observation Stay

- When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed separately.

Obstetrical Observation Stay

When an obstetrical patient is placed in observation status:

- The entire episode is considered an inpatient admission if delivery occurs prior to discharge.
- The episode is considered an observation stay if delivery does not occur and the member is sent home.
- Reimbursement includes diagnostic testing performed in conjunction with an obstetrical observation stay.

Oscar Does Not Reimburse:

Observation stay is not considered an appropriate designation for the following, and is therefore not reimbursed:

- Preparation for, or recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies)
- The routine recovery period following a surgical day care or an outpatient procedure
- Services routinely performed in the emergency department or outpatient department
- Observation care services submitted with routine pregnancy diagnoses
- Retaining a member for socioeconomic factors
- Custodial care

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual
5/5/2016	Update to Policy

Surgical Supplies

Policy

This policy describes the reimbursement methodology for general surgical supplies associated with outpatient physician surgical services. Consistent with CMS, Oscar does not reimburse providers for general surgical supplies.

Reimbursement

Supply Code 99070

For reimbursement of covered medical and surgical supplies, an appropriate Level II HCPCS code must be submitted. The non-specific CPT code 99070 (supplies and materials, except spectacles, provided by the physician, hospital, ambulatory surgical center or other qualified healthcare professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)) is not reimbursable in any setting.

Surgical Tray Code A4550

CPT code A4550 will not be reimbursed separately. This code is considered to be part of a physician's practice expense and thus reimbursement of this code is included in the payment of other codes billed by the physician.

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual

Dual Preventive & Problem-Oriented Visit

Policy

Preventive Medicine Services include annual physical and well child examinations, usually separate from disease-related diagnoses. Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the Preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, Oscar will reimburse the Preventive Medicine service plus the following problem-oriented E/M service codes when that code is appended with modifier 25. If the problem-oriented service is minor, or if the code is not submitted with modifier 25 appended, it will not be reimbursed.

When a Preventive Medicine service and other E/M services are provided during the same visit, only the Preventive Medicine service will be reimbursed.

Screening services include cervical cancer screening; pelvic and breast examination; prostate cancer screening; digital rectal examination; and obtaining, preparing and conveyance of a Papanicolaou smear to the laboratory. These screening procedures are included in (and are not separately reimbursed from) the Preventive Medicine service rendered on the same day for members age 22 years and over.

Publication History

Date	Action/Description
9/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual

Emergent Admissions

Reimbursement Policy

Overview:

Oscar covers emergency services that are medically necessary to screen and stabilize members in a medical or behavioral health emergency. Members who believe they are having a medical or behavioral health emergency are encouraged to seek care at the nearest emergency facility. Neither a referral from the PCP nor prior authorization from Oscar are required. In compliance with the Affordable Care Act (ACA), Oscar covers out-of-network Emergency Health Services at an in-network equivalent benefit level.

An Emergent Admission is defined as an admission to the inpatient hospital level of care immediately subsequent to an Emergency Department (ED) Visit. An example of this may be a patient requiring emergency surgery (e.g. ruptured appendix, multiple trauma, etc.) who is taken to the operating room and admitted to the inpatient setting after discharge from the Recovery Room.

Medical Review:

1. A prior authorization is not required for an emergent admission.
2. All emergent admissions are subject to concurrent and retrospective review.
3. Admitting hospitals are responsible for notifying Oscar of an emergent/urgent inpatient admission **within two business days** following an emergent/urgent admission. Notification may be communicated by fax or phone to Oscar's Medical Operations Team. Phone: 855-OSCAR-55 or Fax: 844-965-9053
4. Oscar may elect to transfer the enrollee to a network facility as soon as medically appropriate. If the enrollee chooses to stay at the non-network facility after the date that it is determined a transfer is medically appropriate, non-network benefits may be applied for the remainder of the inpatient stay.
5. Emergent admissions at in-network facilities must meet the threshold of medical necessity. Emergent admissions at out-of-network facilities must meet the higher threshold of medical necessity and emergency care of sufficient acuity and severity that would not allow the member to have received equivalent care at a later date in an in-network facility

Reimbursement:

1. <u>ED visit is inclusive of inpatient stay:</u>
   If the patient is admitted to the inpatient setting for a condition that the Plan agrees is medically necessary and is subsequent to an ED Visit, the ED visit is inclusive to the inpatient stay.
2. <u>Resubmission of a denied inpatient stay:</u>
   If an admission is denied upon concurrent or retrospective review as not meeting medical necessity criteria for admission to the inpatient setting, the provider may resubmit a claim at an alternate level of care or as an outpatient ER visit to allow payment of the ED visit portion.
3. <u>Itemized bills requested for partially denied inpatient stays:</u>
   If an emergent admission is determined to NOT meet medical necessity criteria for a portion of the stay, Oscar will deny the claim with a request for an itemized bill to split and pay a portion of the claim.
4. <u>Claims denied if notification not provided:</u>
   If an emergent admission is not reviewed prior to claim submission, the claim will be denied with a request for medical records.

Publication History

Date	Action/Description
12/09/2015	Original Documentation
6/16/2016	Approval and inclusion in Oscar Provider Manual

Transfers

Policy:

In cases where a patient is transferred during an inpatient stay between acute care facilities, Oscar reimburses both the transferor and the transferee.

Reimbursement:

For hospitals reimbursed using a DRG base rate, Oscar reimburses the transferring hospital the lesser of the per diem rate and the total negotiated case rate. The per diem rate is calculated by dividing the negotiated rate by the geometric mean length of stay for the assigned DRG. For hospitals reimbursed at a per diem rate, the payment is calculated at the negotiated per diem rate.

The receiving hospital is paid at the negotiated rate.

Publication History

Date	Action/Description
7/21/2016	Original Documentation
7/27/2016	Approval and inclusion in Oscar Provider Manual

Readmissions

Reimbursement Policy

Policy:

For all inpatient stays reimbursed at a case rate, Oscar reserves the right to review readmissions for the same or related conditions within 15 days of discharge.

Reimbursement:

If Oscar determines upon review that a readmission arose from premature discharge or failure of the facility to manage the discharge properly, Oscar will potentially rescind payment for either the readmission or the original stay, regardless of the medical necessity of the readmit.

Publication History

Date	Action/Description
12/09/2015	Original Documentation
6/16/2016	Approval and inclusion in Oscar Provider Manual

Mid-level Providers

Reimbursement Policy

Policy:

This policy describes reimbursement made to mid-level providers.

Reimbursement:

Oscar follows guidelines established by CMS pertaining to mid-level providers. For the specialities listed in the table below, Oscar's reimbursement is equal to the lesser of 80% of billed charges and 85% of the allowed amount for physicians.

Specialty
Physician Assistant
Nurse Practitioner
Certified Clinical Nurse
Nurse Midwife
Certified Surgical Assistant

Publication History

Date	Action/Description
10/14/2016	Original Documentation
10/14/2016	Approval and inclusion in Oscar Provider Manual