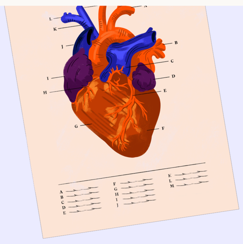
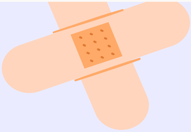
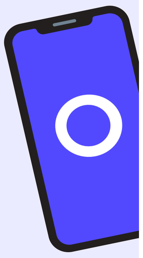
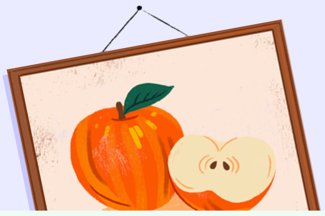




SEPTEMBER UPDATES

Provider Newsletter





Contents

What's going on this month

- Easier tracking of PA requests + more PA codes removed
- 10/1: Must use our new form for claims disputes
- CMS Program Integrity Rule updates

And much more!

Provider Portal Updates

This month in your portal

This month, we’ve added new updates to the Provider Portal to make your work with Oscar fast and easy:

- **Reminder! Claim dispute responses are now digital:** You can now view claim disputes, appeals, and inquiry responses in your portal. Over time, repeat paper mailings will be phased out to help reduce waste and clutter.
- **UM Appeal Response Letters:** When you send an appeal, it will show up in the Auth List View next to your original request. Once a decision is made, you’ll see the decision, the date, and the response letter all in the same row.
- **Easier tracking of prior auth requests:** PAs sent to some vendors (like Ash or Evicore) can now be seen in your portal.* You can also filter by reviewer (e.g., Oscar, Evicore) or by how the request was sent.

**Note: Prescription prior auths are not included right now.*

These changes are part of Oscar’s ongoing commitment to to simplify and streamline your provider experience.

Access Provider Portal

Provider News Updates

New! Clinical documents & coding resources

We have a new Provider Resources page to help you document and code patient care. On this page, you can:

- **Learn:** Find educational materials to help you record and show high-quality patient care.
- **Connect:** Reach our certified medical coders, clinical documentation specialists, and partnering clinicians.
- **Use best practices:** Browse and download our tools, guides, and Clinical Evidencing Series.

Questions or requests on specific topics? Email us at cdi@hioscar.com.

New low-volume bowel prep agents now on formulary

To support improved colonoscopy preparation and patient adherence, we have added several low-volume bowel prep agents to the formulary: **Clenpiq, Suflave, and Plenvu**.

According to AGA guidelines, low-volume prep agents are recommended to help increase the likelihood that patients will complete their pre-treatment plan. These new options not only offer a lower volume and taste better, but are also **available at $0 cost for members ages 45–75**, the recommended age range for colonoscopy screening.

Review Formulary

Policy Spotlights

Help protect enhanced premium tax credits

Many of your patients could be at risk of seeing a huge spike in their premiums – **upward of 90%** – if Congress fails to extend the enhanced premium tax credits that are set to expire on December 31. **As many as 4 million people could lose coverage altogether as a result of premium hikes, and uncompensated care costs could increase by over $6 billion.**

Congress can prevent millions of Americans – **your patients** – from losing their healthcare. But Congress has to act now and renew these critical subsidies in the September government funding bill. As a valued provider, you play a critical role in helping your patients maintain access to care. Now is the time to raise your voice and urge Congress to act.

How you can help: Contact your U.S. Senators and Representatives and urge them to support the extension of these vital tax credits in the September funding bill. Together, we can help protect the affordability and stability of coverage for those who need it most.

Send a Message to your Senators and Representatives Now*

Final CMS program integrity rule

CMS has put their new **Program Integrity Rule*** in place. Your patients may notice changes in how their eligibility is checked and how renewals work. These updates could affect their healthcare costs and whether they can keep their coverage with you.

What you can do: Encourage your patients to check their options and talk to their brokers early this year so they are prepared for Open Enrollment and don't lose their coverage or access to care. They can talk to their broker for help, to understand the new rules, and to avoid gaps in coverage. This will protect their care and make sure you continue to be paid for services.

Learn more about what these policies mean and how we're educating our brokers and members today.

View Informational Resource Hub

*Please note that we are not responsible for the privacy practices or content of third-party websites linked in this email. We encourage you to review the privacy policies of any external sites you visit.

Organizational Updates

More prior auth codes removed

We're excited to share some big changes that make things easier for you and your patients. Last month, we removed prior authorization requirements for more than 1,000 medical services—over 27% of our total! And we're not stopping there.

This month, we're taking **over 100 more procedure codes** off the list, so these services no longer need pre-approval.

We know that less paperwork means more time for you to focus on patient care. We're committed to cutting down on administrative tasks so you can do just that.

Learn More Here

Upcoming change to prior authorization process

Starting soon, claims sent without prior authorization will no longer stay in a "pending" status. They will be denied instead, following industry standards. You'll also see these updates in the 2025 Provider Manual. If you have questions, reach out to our Provider Services team at (855) 672-2755, option 4. Stay tuned for further details in our next newsletter.

View Provider Manual

Reminder: Must use our new cover forms for claim disputes by

10/1

The best way to submit your claim dispute and stay up to date on its status is through our **Provider Portal**. We've made necessary changes so that submitting through your portal is easier than ever before!

Beginning October 1, if you choose to submit your dispute through fax or mail, you **must** include the necessary cover sheet for it to be processed, or your dispute will be returned until the form is used.

Our claims dispute forms can be found at **hioscar.com/providers/cover-forms**.

How do you know which form to use?

- If you are challenging a claims determination:
  - Use the **Claims Dispute** Provider Form
- If you are challenging an authorization denial for medical necessity or experimental/investigational procedures:
  - Use the **Clinical Appeals** Provider Form
- If you are sending us additional documentation regarding an individual claim (including medical records, itemized bills, acquisition invoices)
  - Use the **Claims-Related Documents** Provider Form
  - This form is NOT to be used for initial claim submission

We recommend saving these cover forms to your files for easy future reference. Find the documents by clicking the button below.

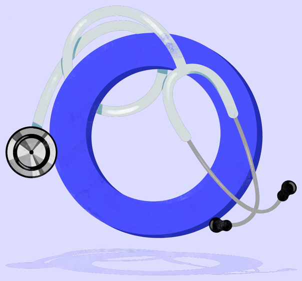
Provider Forms

Friendly Reminder

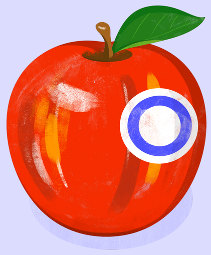
Appointment wait time standards

Many Americans experience long wait times for healthcare, and some even delay or skip care because they can't see a doctor promptly. **These delays are linked** to lower patient satisfaction, negative perceptions of care quality, and higher no-show rates. Prolonged wait times can also lead to worsening health conditions, delayed diagnoses, and potentially preventable hospitalizations.

We know you're already committed to providing timely, high-quality care to your patients. Here's a quick reminder about the appointment timeframes established by CMS for qualified health plans:



Behavioral health
appointments within
10 days*
business



Routine Primary Care
appointments within
15 days*
business

Specialty Care
appointments within
30 days*
business

We understand the demands on your time and appreciate your continued efforts to meet these important standards. Thank you for your partnership and commitment to caring for our members the way you do!

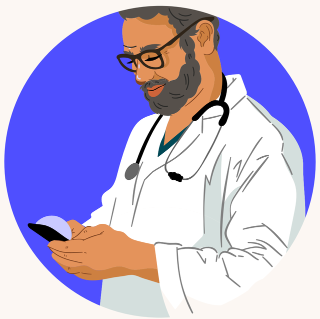
Check out the Provider Manual for more comprehensive guidelines.

Provider Manual

FAQ/Resources

You have questions, we have answers

We know that getting you the information you need, when you need it, is essential to getting patients the care they need. That’s why we’ve developed online provider resources that you can access 24/7.



Provider Resource hub

Access a variety of tools like videos and how-to guides for common tasks

Learn more

Provider Manual

View policy and procedure information by state

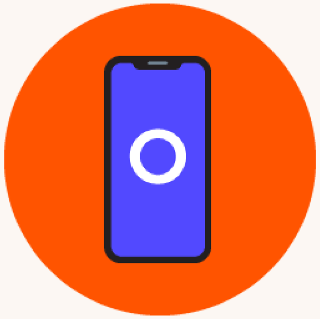
Learn more

FAQ’s

Check out answers to some of our most commonly asked questions

Learn more

Want to talk to us directly? Reach out to our Provider Services team at (855) 672-2755, then press 4.



Got a minute?

Share your thoughts so we can make this newsletter work better for you.

Take Survey

Questions?
Our Oscar Business team is here to help at
855-672-2755 or business@hioscar.com.

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