APRIL 2025

Provider News

For participating physicians, other health care professionals and facilities

In this issue

Automate your pre-authorization process with Availity Essentials

Receive fast responses to authorization requests for behavioral health and substance use services, with some requests receiving automated approval.

Advanced imaging facilities need to register with OptiNet

Carelon will begin reviewing radiology site of care requests submitted on or after May 1, 2025. Register with OptiNet to ensure Carelon has accurate information when determining the appropriate site of care for MRIs and CTs for our commercial members.

Opt-in to our quality incentive program by June 30, 2025

Continue to partner with us to address gaps in patient care. View our 2024 and 2025 program updates.

Visit the new Quality in Action section

This new section on our provider website aims to help you improve patient engagement and health outcomes.

Using our website

When you first visit **bridgespanhealth.com**, you will be asked to select an audience type (individual or provider) and enter a ZIP code for your location. This allows our site to display content relevant to you.

Contents

■ Critical update ★ Stars Ratings/Quality ● Radiology

BridgeSpan Health
2890 E Cottonwood Parkway Salt Lake City, UT 84121

Get the latest news

We publish the latest news and updates in the What's New section on the homepage of our provider website.

Subscribe to receive email notifications when new issues of our publications are available.

Provider News

This publication includes important news, as well as notices we are contractually required to communicate to you.

In the table of contents on page 1, this symbol indicates articles that include critical updates: ■. Click on article titles to go directly to that page, and return to the table of contents by clicking the link at the bottom of each page.

We publish issues of *Prodiver News* on the first of February, April, June, August, October and December.

Provider News includes information for BridgeSpan Health in Idaho, Oregon, Utah and Washington. When information does not apply to all four states, the article will identify the state(s) to which that specific information applies.

The information in this newsletter does not guarantee coverage. Verify members' eligibility and benefits via Availity Essentials.

The Bulletin

Published monthly, *The Bulletin* summarizes updates to medical and reimbursement policies, including policy changes we are contractually required to communicate to you.

Medical record signature requirements

Proper authentication of medical records is crucial for health plans and providers to ensure that the data we report to CMS is compliant and accurate. Missing or improper signatures discovered through post-payment medical record reviews (such as those for risk adjustment) can lead to claim recoupments.

- All medical records must include the provider's valid signature, credentials and signature date.
- Providers have 180 days from the date of service to amend a record to properly authenticate it (including by recording a valid signature).
- Electronic medical record (EMR) system updates may override signature settings, requiring re-verification.

Tips to stay compliant

Using these tips to update and maintain your documentation practices can help you ensure proper authentication is happening in all your medical records:

1. Review your current signature practices.
2. Ensure all staff understand proper authentication requirements.
3. Keep CMS documentation guidelines readily available.
4. Regularly verify EMR signature settings, especially after system updates.
5. Limit EMR print settings to completed and signed records.
6. Regularly audit EMR for unsigned records and sign them (within 180 days of the date of service).

Resources

- The Medical Record Requirements section of our Administrative Manual, available on our provider website
- Visit the CMS website to access these helpful MLN fact sheets:
  - Medical Record Maintenance & Access Requirements (MLN4840534)
  - Complying with Medical Record Documentation Requirements (MLN909160)
  - Complying with Medicare Signature Requirements (MLN905364)

$0 claim submission tips

Submitting medical claims with $0 or $0.01 charges may be helpful for quality measure reporting or ensuring that we have all appropriate diagnoses documented in a calendar year for your patients. Here are some helpful tips for submitting these claims:

Reporting codes for quality

1. Submit a claim with an applicable evaluation and management (E&M), annual wellness visit (AWV) or preventive care CPT visit code on a professional claim. This code must have a billed charge more than $0. Additional CPT, CPT II and HCPCS codes (such as M1299 for flu vaccination documentation) can be included on the initial claim with a billed charge of $0 for that line.
2. To submit CPT reporting, additional CPT, CPT II and HCPCS codes on a standalone claim, the billed charge should be $0.01.

Risk adjustment diagnoses

1. Submit a claim with an applicable evaluation and management (E&M), annual wellness visit (AWV) or preventive care CPT visit code and up to 12 diagnosis codes for risk adjustment on a professional claim.
2. To submit additional diagnosis codes for risk adjustment, submit a second claim using CPT 99499 with a billed charge of $0.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.
3. If additional diagnosis codes for risk adjustment remain, submit an additional claim for CPT 99499 with modifier 25 and a billed charge of $0.01. **Note**: CPT 99499 must be the **only** CPT code on this claim.

Verify your directory information

Accurate provider directories are essential to help members find providers who best meet their health care needs and individual preferences, such as:

- Language access
- LGBTQIA+-affirming care
- Culturally specific services
- Disability-competent care

When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

Provider directories, verified and updated at least every 90 days, are a requirement for compliance with the Consolidated Appropriations Act (CAA), the Affordable Care Act (ACA) and your agreement as a network provider with BridgeSpan.

- Review our Provider Directory Attestation Requirements for Providers policy.
- Follow the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.

Correct coding updates

Providers are expected to follow correct coding guidelines. We are providing courtesy notice that our correct coding editors will apply denials for claims received on or after:

Post-pay edit effective April 1, 2025

- Laboratory charges for post-vasectomy semen analysis
  - Semen analysis is included in the reimbursement of the vasectomy and is not separately payable.

Pre-pay edits effective May 9, 2025

- Blood products
- Global modifiers
- Radiology transportation

These reviews are supported by industry standards and our *Correct Coding Guidelines* (Administrative #129) reimbursement policy. View our *Reimbursement Policy Manual* on our provider website: Policies & Guidelines>Reimbursement Policy.

Pre-authorization updates

Procedure/medical policy	Added codes effective April 1, 2025
Cardiovascular—Carelon	0913T
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	0539U
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	0538U, 0543U
Procedure/medical policy	**Adding codes effective July 1, 2025**
Air Ambulance Transport (Utilization Management #13)	A0431, A0436, S9961
Cardiovascular—Carelon	C7557, C7558
Electromagnetic Navigation Bronchoscopy (Surgery #179)	31626, 31627, C7509-C7511, C9751
Radiology—Carelon	75580

Our complete *Pre-authorization List* is available in the Pre-authorization section of our provider website. Please review the list for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through the Availity Essentials Electronic Authorization application.

Radiology site of care: Register with OptiNet today

Advanced imaging facilities need to register with OptiNet as soon as possible to ensure Carelon has accurate information when determining the appropriate site of care for MRIs and CTs for our commercial members. Carelon will review the site of care for requests submitted on or after May 1, 2025.

OptiNet is an online application accessed through the Carelon provider portal that collects service and capability information about outpatient providers. Carelon uses that information to determine available sites for services.

Facilities that should register with OptiNet

Providers that bill place of service (POS) 11, 49 or 81—designated as a freestanding imaging facility (physician group)—are required to register. Facilities billing POS 19 or 22 are designated as outpatient hospital departments and do not need to register with OptiNet.

If a facility doesn't register with OptiNet: Carelon won't be able to determine whether a service should be performed at that facility. An unregistered facility may:

- Fail to have services redirected to their facility
- Unnecessarily have services redirected to another facility

To register or update your facility information: Sign in to the Carelon provider portal and select **Access Your OptiNet Registration**.

If you're registered with OptiNet for another health plan: You can easily add your BridgeSpan registration using the copy-and-paste function in OptiNet.

Have questions?

- **Attend a training**: Register today to attend a webinar about the radiology site-of-care program, using the Carelon provider portal and registering with OptiNet.
- **Contact OptiNet customer service**: Call 1 (877) 202-6543 or email.

The Bulletin recap

We publish updates to medical and reimbursement policies in our monthly publication, *The Bulletin*. You can read issues of *The Bulletin* or subscribe to receive an email notification when issues are published on our provider website: Library>Bulletins.

Medical policy updates

No medical policies in the February 2025 issue of *The Bulletin* required 90-day notice.

We provided 90-day notice in the March 2025 issue of *The Bulletin* about changes to the *Bariatric Surgery* (Surgery #58) medical policy, which are effective June 1, 2025.

Easily search our *Medical Policy Manual*

From the medical policy manual table of contents, you can search for a policy by:

- Policy name
- Medical policy ID
- Keywords
- CPT or HCPCS codes

You can also filter category names to browse policies by section or filter alphabetically by policy name or ID.

The manual also includes a list of recent updates and archived policies and is available on our provider website: Library>Policies & Guidelines>Medical Policy.

Reimbursement policy updates

No reimbursement policies in the February 2025 and March 2025 issues of *The Bulletin* required 90-day notice.

View our *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines> Reimbursement Policy.

Updated Carelon guideline effective date

Carelon's Imaging of the Abdomen and Pelvis advanced imaging clinical guideline will now be updated May 18, 2025.

Visit the Coming Soon section of Carelon's website to view the revised guidelines.

eviCore updating musculoskeletal guidelines

Effective July 1, 2025, eviCore healthcare (eviCore) will revise the following advanced musculoskeletal clinical guidelines:

Joint surgery

- Shoulder Arthroplasty/Replacement/Resurfacing/ Revision/Arthrodesis

Interventional pain

- Greater Occipital Nerve Injections and Ablation

Spine surgery

- Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)
- Sacroiliac Joint Fusion and Stabilization

Visit eviCore's website and select the Future tab to view the revised guidelines.

Clinical Practice Guideline updates

Clinical Practice Guidelines are systematically developed statements on medical and behavioral health practices that help providers make decisions about appropriate health care for specific conditions.

We reviewed the following Clinical Practice Guidelines, effective February 1, 2025:

Clinical Practice Guidelines for Perinatal Care

- No changes to the guideline recommendation

Treatment of Depression in Adults

- Replaced the primary reference with a recent guideline from the American College of Physicians: Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline from the American College of Physicians (2023)
- Updated links and clarified some of the Position Statement language to align with other Clinical Practice Guidelines
- Added two guidelines to additional resources:
    - The American Psychiatric Association practice guidelines for the treatment of patients with major depressive disorder (2015)
    - The American Psychological Association clinical practice guideline for the treatment of depression across three age cohorts (2019)

View the guidelines on our provider website: Library>Policies & Guidelines>Clinical Practice Guidelines.

Medication policy updates

Effective July 1, 2025, we will make changes to the following medication policies:

- *Camzyos, mavacamten*, dru720
- *CGRP Monoclonal Antibodies*, dru540
- *Hemlibra, emicizumab-kxwh*, dru539
- *Medications for transthyretin-mediated amyloidosis*, dru733
- *Provider-Administered Specialty Drugs*, dru764
- *Self-administered CGRP antagonists and 5-HT 1f agonists*, dru635
- *Site of Care Review*, dru408

Effective January 1, 2026, we will make a change to the *Drugs for chronic inflammatory diseases*, dru444 medication policy.

We now post required notification and information about medication policy additions and changes on our website: Policies & Guidelines>Medication Policy Updates. Visit this page to see new notifications on the first of the following months: February, April, June, August, October, December. Providers are responsible for obtaining pre-authorization as required in our medication policies.

BridgeSpan EquaPathRx™ updates

Oregon providers

Our benefit administration transition date for Oregon will be announced in a future issue of this newsletter.

Learn more about the BridgeSpan EquaPathRx program on our provider website: Programs>Medical Management>Pharmacy.

Behavioral health corner

About behavioral health corner

This corner has content dedicated to behavioral health providers. As with any specialty, other content in this newsletter will apply to your practice. We recommend reviewing the articles listed here, as well as using the search function (Ctrl + F) on your computer to search for keywords that concern your practice.

Therapy code reimbursement to increase for Washington providers

Washington-based providers: Effective July 1, 2025, we will increase reimbursement rates for CPT 90837 (*psychotherapy, 60 minutes with patient*) for behavioral health providers on standard professional services agreements. This is an off-cycle reimbursement change.

The updated reimbursement rates will be posted by the effective date in Availity Essentials: Claims & Payment> Fee Schedule Listing.

Automate your pre-authorization process with Availity Essentials

When patients need behavioral health or substance use care, they need it quickly. Availity Essentials is a powerful, easy-to-use tool that can help simplify your pre-authorization process and reduce manual work. It can be used to quickly see whether services require pre-authorization and to submit a request.

There is no need to call or fax a request to us: Requests submitted via Availity Essentials are processed in real-time, with some requests receiving automatic approval, reducing wait times for care. This means your patients can receive the care they need when they need it most.

By using Availity Essentials, you can:

- **Receive fast responses to authorization requests for behavioral health and substance use services, with some requests receiving automated approval**
- Reduce wait times for care, allowing you to provide timely and effective treatment to your patients
- Access all requests in the Auth/Referral Dashboard, making it easier to track and manage patient care
- Reduce manual work and increase efficiency, allowing you to focus on what matters most—providing high-quality care to your patients

We are continually making improvements to our electronic authorization tools for a better provider experience. Over the coming year you can expect to see more functionality customized for behavioral health providers.

Take the first step

Don't wait—register for Availity Essentials today and start experiencing the benefits of a streamlined authorization process.

Resources

Training is available after signing in to Availity Essentials: Help & Training>Get Trained>Catalog>Authorization Request - Training Demo. A quick reference guide is also available in the content section after you enroll in the authorization training. It includes instructions and screenshots to help you through the electronic authorization process.

You can also learn more about electronic authorization or view our step-by-step guide on our provider website: Pre-authorization>Electronic Authorizations.

State-funded psychiatric consultations assist PCPs

PCPs in Oregon, Utah and Washington can access free psychiatric consultations through state-funded programs. These services help bridge the gap in behavioral health care delivery and support better patient outcomes.

Psychiatric consultation services:

- Expand access to limited psychiatric resources
- Provide cost-free support for providers and patients at no cost
- Offer diagnostic clarification and treatment guidance
- Assist with medication management decisions
- Facilitate appropriate referrals for serious cases

They also impact health care delivery by:

- Enhancing early intervention
  - Improves quality of care
  - Leads to better health outcomes
- Integrating care
  - Promotes coordination between mental and physical health services
  - Supports whole-person care

The consultation process:

- Is simple and streamlined
- Doesn't require additional patient authorization
- Is covered under HIPAA as a provider-to-provider consultation

Important: Psychiatric consultations are designed for treatment planning and best practices discussion only. **For psychiatric emergencies, call 911.**

Note: Idaho currently does not offer a state-funded consultation program.

State program comparison	Oregon	Utah	Washington
Program	Oregon Psychiatric Access Line (OPAL)	Consultation Access Link Line to Utah Psychiatry (CALL-UP)	Partnership Access Line (PAL)
Consultation line	1 (855) 966-7255 or (503) 346-1000	(801) 587-3636	(866) 599-7257
Hours	9 a.m. to 5 p.m. PT, weekdays	9 a.m. to 5 p.m. MT, weekdays	8 a.m. to 5 p.m. PT, weekdays
Ages served	Children, adolescents and adults	Children, adolescents and adults	Children and adolescents up to age 19
Partners	- Oregon Health and Science University (OHSU) psychiatry divisions - Oregon Pediatric Society - Oregon Council of Child and Adolescent Psychiatry	- University of Utah's Huntsman Mental Health Institute - Office of Substance Use and Mental Health	- Seattle Children's Hospital - Washington's Health Care Authority - Mental Health Referral Service for Children and Teens - Frontier Behavioral Health
Notes	- For questions, email OPAL - Same-day consultations available; developmental behavioral pediatrics consultations require an appointment	- For questions, email CALL-UP - Consultation requests can also be submitted online	Direct access to child psychiatrists

Behavioral health corner

Behavioral health resources to support PCPs

PCPs play a crucial role in behavioral health care, from initial discussions and diagnosis to ongoing condition management. To support this vital work, our Behavioral Health Toolkit includes information about many resources and tools available to PCPs:

- Overviews of 12 common behavioral health conditions, as well as related screening tools and evidence-based clinical resources
- Virtual care solutions
    - Members have direct access to in-network virtual providers who cover a wide range of specialty services.
    - There is no referral requirement.
    - Virtual providers can improve access to timely care.
- Our care management services, including case management
- Determining the best path forward in the early stages of a patient's evaluation and treatment, as well as ongoing condition management
    - Providers in Oregon, Utah and Washington have access to state-funded, no-cost psychiatric consultations. **Related**: See *State-funded psychiatric consultations assist PCPs* on page 8.
- Social determinants of health (SDoH)
    - PCPs are ideally positioned to identify and address patients' social needs and risk factors. By monitoring SDoH, we can identify and resolve barriers to care, promote equitable access to care and enhance health education efforts.

The Behavioral Health Toolkit is available on the homepage of our provider website.

Quality in Action: Improve patient engagement and health outcomes

We're dedicated to empowering providers with resources to enhance patient engagement and drive better health outcomes.

Check out the new Quality in Action section on our provider website to:

- Discover how you can partner with us to elevate the standard of care and make a more meaningful difference in the lives of your patients.
- Explore our best practices newsfeed, as well as links to our quality programs, toolkits and publications.

Read these articles, which we've recently added to our best practices newsfeed:

- Cancer screenings and prevention
- Improving members' experience with medications
- Resources for addressing social determinants of health
- Statin use for cardiovascular disease or diabetes
- Taking control of tomorrow: National Healthcare Decisions Day
- Tobacco cessation resources for providers and patients

2025 QIP updates

We want to keep you informed about the status of our 2025 Quality Incentive Program (QIP). Currently, some details are still being finalized. In the meantime, you can still access 2025 care gaps in your Care Gap Management Application (CGMA) dashboard.

What's New for 2025

Healthcare Effectiveness Data and Information Set (HEDIS®) has retired the Antidepressant Medication Management (AMM) measure, and it has been removed from our program.

Program information

We will share 2025 program details on our provider website as soon as they are finalized: Programs>Quality Incentive.

You will also receive notification through our CGMA Monday Morning emails.

New and updated features in the CGMA

We continue to partner with Novillus to improve the CGMA and have implemented the following enhancements for 2025:

- **Providers will opt-in** to the 2025 program through the CGMA by June 30, 2025.
- The **scorecard has been redesigned** to include measure weight and performance-only data.
- We have **enhanced reporting capabilities** by adding:
  - The full provider group name
  - The ability to easily view/access included TINs
  - The ability to download all scorecards for a single roll-up group
- We have added a **new member indicator** on gaps

To add users, your Commercial QIP primary contact can submit a ticket on the CGMA.

For questions, email our QIP team.

Resources for you

Use our Self-Service Tool, available 24/7, to review helpful answers to our most frequently asked questions and quickly navigate our provider website resources.

Publications team

Written, designed and edited by the Provider Communications team.