

JUNE 2026

Provider News

For participating physicians, other health care professionals and facilities



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Opt-in to our 2026 CCAP

Providers must opt-in via the Care Gap Management Application (CGMA) by June 30 to participate in our 2026 Chronic Conditions Assessment Program (CCAP).

Provide input on our medical policies

We value your opinions about coverage criteria for procedures, equipment and services that affect their practice, and we welcome participation in our medical policy review process.

Updates to chiropractic billing policy

We are updating our chiropractic billing rules effective October 1, 2026, to align with the services chiropractors can legally perform in each of our service areas.

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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.



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 *Provider 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.

Administrative Manual updates

We published the following updates to our manual on June 1, 2026:

Appeals for Providers

- Added failure to provide medical records as a qualifying reason within the provider dispute definition.

Complementary & Integrative Care

- For changes effective October 1, 2026: Simplified the chiropractic information to redirect providers to the reimbursement policy

Oregon only: Electrolysis Services

- New section regarding documentation and claims submission for electrolysis services

Our manual sections are available on our provider website: [Library>Administrative Manual](#).

Submit inpatient hospital notifications electronically ahead of September 1 requirement

Providers are encouraged to begin acute inpatient hospital notifications and clinical records electronically through Availity Essentials starting in July. This early access allows time to become familiar with the process ahead of the September 1, 2026 requirement, when electronic submission will be required for admission and continued stay reviews. **Note:** Fax submissions will only be accepted for [approved exceptions](#).

If you submit an inpatient admission notification via [PointClickCare](#) (PCC) and we have access to your EMR, we may treat it as a request for review. If EMR access is not granted **or** we are unable to retrieve records in the EMR, then the request must be submitted via Availity Essentials.

Next steps

- Get Availity access: If you are not already using Availity Essentials, [register for free](#).
- Grant permissions: If you use an EMR, you can give us access to retrieve clinical records.
- Learn more: For help navigating Availity Essentials, go to Help & Training>Get Trained and search for Authorization Request (New) - Training Demo.

Chiropractic billing alignment with state licensing scope

After thorough internal review, we are updating our chiropractic billing rules to align with the services chiropractors can legally perform in each of our service areas.

Effective October 1, 2026: We are revising our *Chiropractic and Osteopathic Treatments* (Administrative #138) reimbursement policy to better align with state-determined scope of practice regulations, as well as industry standards. The policies only apply to chiropractors practicing in our service area.

Chiropractors will also be required to obtain pre-authorization for services listed on our Pre-authorization list. **Related:** See *Pre-authorization updates* on page 5.

These changes may affect which services are reimbursable by your practice.

Summary of policy updates

- Changing list of reimbursable services to align with state guidelines
 - Note: Services are reimbursable according to the billing provider's scope of license in the location where services are rendered, subject to all local and federal laws.
- Adding definition of chiropractic manipulative treatment (CMT)
- Adding list of billable codes
- Removing HCPCS S8990 from the osteopathic treatment section
- Specifying that correct coding guidelines include (but are not limited to) using appropriate modifiers and billing according to scope of practice as defined by the applicable state licensing authority
- Clarifying that osteopathic care is not reimbursable by chiropractors

Note: When billing acupuncture codes, providers are required to submit claims under their acupuncturist license.

Resources on our provider website

- View the list of reimbursable codes in the Chiropractic and Osteopathic Treatments (Administrative #138) reimbursement policy in our Reimbursement Policy Manual: [Library>Policies & Guidelines>Reimbursement Policy](#).
- We announced the policy changes in the June 2026 issue of The Bulletin: [Library>Bulletins](#).
- View the updated Complementary & Integrative Care section of the [Administrative Manual](#).
- View services that require [Pre-authorization](#).

State resources

- [Idaho Association of Chiropractic Physicians](#)
- [Oregon Chiropractic Association](#)
- [Utah Chiropractic Physicians Association](#)
- [Washington State Chiropractic Association](#)

Other resources

- [CMS chiropractic services and billing](#)
- [American Chiropractic Association](#)
- [International Chiropractors Association](#)

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](#).

Compliance program requirements

All providers and their staff, including any board or trustee members must meet the requirements of our Government Programs compliance program. These requirements include:

- Monthly verification that they are not on an exclusion list
- Annual training on compliance and fraud, waste and abuse (FWA)

We contract with CMS to provide health care services to members with coverage on Qualified Health Plans (QHP). Through these contracts, we must oversee the downstream and delegated entities (DDEs) that assist us in providing services for our QHP beneficiaries.

Exclusion lists

All QHP-contracted providers, medical groups, facilities and suppliers are required to check the Office of Inspector General (OIG) and General Services Administration (GSA) federal exclusion lists for all employees prior to hire and monthly thereafter.

We are prohibited from paying government funds to any entity or individual found on these federal lists:

- [GSA exclusion list](#)
- [OIG exclusion list](#)

Notes:

- If an employee is confirmed to be excluded, he or she must immediately be removed from working on our government programs.
- Documentation of these verifications must be maintained and made available upon request by either BridgeSpan or CMS.
- We ask contracted entities to verify they are compliant with this requirement during initial credentialing and at recredentialing.

Mandatory compliance training

Compliance training is a contractual requirement for participation in our QHP networks. This training must be completed within 90 days of hire and annually thereafter.

Please ensure that your staff complete the required training and maintain documentation for auditing purposes for:

- FWA
- General compliance

Compliance for board and/or trustee members

Your organization's board or trustee members are required to participate in all BridgeSpan Government Programs compliance activities, including:

- Signing a conflict-of-interest disclosure at appointment and annually thereafter
- Completing OIG and GSA screenings prior to appointment and monthly thereafter
- Completing FWA and general compliance training within 90 days of appointment and annually thereafter

Documentation must be maintained and made available upon request by either BridgeSpan or CMS.

Learn more

More information about our compliance program and related resources are available on our provider website:

- [Library>Policies & Guidelines>Guidelines>Government Programs Compliance Tips](#)
- Qualified Health Plans section of the Administrative Manual: [Library>Administrative Manual](#)

Pre-authorization updates

Procedure/medical policy	Added codes effective April 1, 2026
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- G0681-G0684
Digital Therapeutic Products (Medicine #175)	- A9294
Digital Therapeutic Products for Post-traumatic Stress Disorder and Panic Disorder (Medicine #175.05)	- A9294
Hypoglossal Nerve Stimulation (Surgery #215)	- C8007, C8008, C8011, C8012
Procedure/medical policy	Added codes effective May 1, 2026
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- Q4160
Procedure/medical policy	Adding codes effective August 1, 2026
Cervical Spinal Fusion (Surgery #244)	- 22551, 22552, 22554, 22600, 22853, 22854, 22859
Procedure/medical policy	Adding codes effective October 1, 2026
Services provided by chiropractors	- 95851, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032-97036, 97039, 97110, 97112, 97113, 97116, 97139, 97140, 97150, 97161-97164, 97530, 97750
Related: See <i>Chiropractic billing alignment with state licensing scope</i> on page 3.	

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 and behavioral health pre-authorizations through the Availity Essentials [Electronic Authorization application](#).

Attestation language updated

Effective June 1, 2026, attestation language was updated across policies with attestation requirements to improve clarity and ensure consistent, accurate submissions.

When submitting authorization requests, providers attest that the selected policy criteria accurately apply to the requested service and that the supporting clinical documentation aligns with that selection.

The updated language more clearly states that, by submitting a request, providers confirm that the information provided is true, and the submitted documentation accurately and comprehensively supports the selected criteria.

Providers should continue to carefully review policy criteria, ensure documentation supports the criteria selected, and submit attestations only when all requirements are met.

New program helps patients successfully transition after hospital discharge

We’ve enhanced our inpatient hospital utilization management program with a team of dedicated clinicians who assist with discharge planning and provide post-discharge support to members at risk of readmission.

Collaborative engagement with providers to help meet members’ needs is critical to this program’s success.

- During the admission: Our clinicians engage providers and members to begin support conversations and discharge planning.
- Post-discharge: We remain in contact with members at least weekly for up to 30 days to provide the support needed to maintain health in the outpatient setting.

This program is designed to:

- Provide wrap-around support to our most vulnerable members to help them regain and maintain health
- Reduce the number of readmissions
- Reduce avoidable extensions of hospital stay by facilitating transitions of care for members and providers

We look forward to collaborating with our provider partners to make a real difference for the members and families we serve.

Carelon revising cardiology and radiology guidelines

Effective September 16, 2026, Carelon Medical Benefits Management (Carelon) will revise the following cardiology and radiology clinical guideline:

Cardiology

- Imaging of the Heart
- Diagnostic Coronary Angiography
- Percutaneous Coronary Intervention
- Transcatheter Ablation for Management of AF and SV&V Arrhythmia—combining two guidelines; new guideline to be titled Transcatheter Ablation for Management of Atrial Fibrillation and Supraventricular and Ventricular Arrhythmias

Radiology

- Imaging of the Extremities
- Imaging of the Spine
- Nuclear Medicine Imaging
- Vascular Imaging—separating content into two guidelines:
 - Advanced Imaging for Vascular Indications
 - Vascular Ultrasound and Physiologic Testing

Visit the **Coming Soon** section of Carelon's website to view all [revised guidelines](#).

MCG guideline updates

MCG revises its proprietary guidelines annually. We will implement the 2026 guidelines on June 1, 2026. Updated criteria are available in Availity Essentials.

EviCore updating interventional pain guideline

Effective September 1, 2026, EviCore healthcare (EviCore) will revise the Epidural Steroid Injections (ESI) joint surgery & interventional pain clinical guideline.

Visit EviCore's website and select the **Future** tab to view the [revised guidelines](#).

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

We provided advance notice about the following medical policy changes in recent issues of *The Bulletin*.

Issue: April 1, 2026

Effective date: July 1, 2026

- Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)
- Hysterectomy (Surgery #218)
- Lumbar Spinal Fusion (Surgery #187)
- Spinal Cord and Dorsal Root Ganglion Stimulation (Surgery #45)
- Surgical Site of Care – Colonoscopy and Sigmoidoscopy (Utilization Management #20)
- Surgical Site of Care – Hospital Outpatient (Utilization Management #19)

Issue: May 1, 2026

Effective date: August 1, 2026

- New policy: Cervical Spinal Fusion (Surgery #244)

The *Medical Policy Manual* includes a list of recent updates and archived policies and is available on our provider website: [Library>Policies & Guidelines](#).

Reimbursement policy updates

We provided advance notice about the following reimbursement policy changes in recent issues of *The Bulletin*.

Issue: April 1, 2026

Effective date: July 1, 2026

- Drugs, Immunizations/Vaccines, Radiopharmaceuticals, and Skin Substitutes Reimbursed Under Medical Coverage (Medicine #104)
- Modifiers 80, 81, 82, AS; Assistant at Surgery (Modifiers #109)

No reimbursement policies in the May 2026 issue of *The Bulletin* required advance notice.

View our *Reimbursement Policy Manual* on our provider website: [Library>Policies & Guidelines>Reimbursement Policy](#).

Provide input on our medical policies

We value providers' opinions about coverage criteria for procedures, equipment and services that affect their practice, and we welcome participation in our medical policy review process.

View upcoming policy reviews

We post the annual review schedule for all active medical policies on the Upcoming Reviews section of the *Medical Policy Manual* on our provider website: [Library>Policies & Guidelines>Medical Policy Manual>Upcoming Policy Reviews](#).

Get an email reminder

Practicing physicians and other health care providers may subscribe to receive emails about upcoming policy reviews by completing the *Contacting Medical Policy Staff* form on the Upcoming Reviews section of the *Medical Policy Manual*.

Subscribers will receive an email two to three months before a policy's scheduled annual review. The email lists the policy reviews we are requesting feedback on—organized by specialty—so you can quickly identify policies that match your expertise.

Two ways to provide feedback

- Reply to the medical policy review email.
 - You can also share the link with colleagues interested in providing feedback.
- Complete the *Contacting Medical Policy Staff* form, available on the Upcoming Reviews section of the *Medical Policy Manual* on our provider website: [Library>Policies & Guidelines>Medical Policy Manual>Upcoming Policy Reviews>Contacting Medical Policy Staff](#).

Reviewer names and comments are kept confidential.

Medication policy updates

Effective September 1, 2026, we will make changes to the following medication policies:

- Ofev, nintedanib, dru369
- Medications for Multiple Myeloma, other Cancers, and other Hematologic Disorders, dru672

View medication policy additions and changes on our website: [Policies & Guidelines>Medication Policy Updates](#). Providers are responsible for obtaining pre-authorization as required in our medication policies.

Important update for ustekinumab product coverage

Effective July 1, 2026, we're updating our preferred ustekinumab products to include only:

- Steqeyma (ustekinumab-stba)
- Yesintek (ustekinumab-kfce)

All other ustekinumab products, including Stelara, will be non-preferred and require additional approval.

Simplifying the transition for members

Members must transition to a preferred product by their first prescription fill on or after July 1, 2026. Here's how we're making this transition as simple as possible for you and your patients:

- For those with existing ustekinumab pre-authorizations, new pre-authorization requests for Steqeyma and Yesintek will not be required. We will automatically convert them to cover Steqeyma and Yesintek.
- Our preferred products are interchangeable biosimilars to Stelara, but some pharmacies may still require a new prescription for Steqeyma or Yesintek.
- Continued coverage of any non-preferred ustekinumab products, such as brand Stelara, will require a new pre-authorization and will only be covered if both Steqeyma and Yesintek are not treatment options.

In the April 2026 issue of this newsletter, we included notification of the change to our medication policy, *Drugs for Chronic Inflammatory Diseases* (dru444), which will reflect these changes effective July 1, 2026. The policy is available in the *Medication Policy Manual* on our provider website: [Library>Policies & Guidelines>Medication Policy](#).

Quality in Action articles

To help you deliver high-quality, patient-centered care, our provider website offers a growing library of articles, tools and best practice resources designed to support your practice. These materials span key areas, such as member experience, preventive care, care coordination and quality improvement—each aimed at strengthening the patient experience and improving health outcomes.

The [Quality in Action](#) section on our provider website is an extension of this publication and includes practical, evidence-based information to support the work you do every day.

Read the following recently published articles to improve your patients' experience and health outcomes:

- Behavioral health: Updated behavioral health resources to support PCPs
- Low-dose aspirin to prevent preeclampsia (Washington only)
- Maximizing the impact of well-child visits
- Prioritizing women's health
- Supporting wellness through routine checkups
- Test result follow-up processes impact patient outcomes

Chronic Conditions Assessment Program (CCAP) updates

CCAP rewards participating PCPs for accurate coding and complete, consistent documentation of chronic conditions. Provider groups are eligible to earn an incentive for closing the minimum threshold of risk adjustment diagnosis gaps for suspected and persistent diagnoses on their attributed/assigned members chronic conditions.

This program focuses on improving care for our Individual on-exchange members.

Opt-in to the programs

Your QIP primary contract must log into the Care Gap Management Application (CGMA) by June 30, 2026, and follow the on-screen instructions to opt in. **Note:** Providers who have not opted in by June 30, 2026, will not be eligible for incentive payments for the 2026 program.

To request access or reactivate your CGMA account, [email our QIP team](#) and provide the following information:

- User first name
- User last name
- Tax identification number (TIN)
- Provider group name
- Type of access requested (single TIN or multi-TIN group administrator)
- Email address
- Title
- Phone number

Review gaps in CGMA

You can now review identified suspected and persistent diagnosis gaps for patients attributed to you as part of your pre-visit planning on our CGMA through Novillus LLC.

Note: Claim gap closures now display fully.

For more information

Learn more about this program on our provider website: [Programs>Chronic Conditions Assessment Program](#).

If you have questions about this program, [email our QIP team](#).

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.

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- Updated behavioral health resources to support PCPs is published in the Quality in Action section of our provider website.	

Reimbursement changes for ABA and addiction services

Effective September 1, 2026, we will update reimbursement rates for applied behavior analysis (ABA) services and alcohol and drug treatment services (ADTS).

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

Triage line for behavioral health clinical support

Providers who need support with behavioral health clinical concerns can call our Behavioral Health Triage Line, which is intended:

- For clinical support only, including care management assistance and help locating behavioral health providers or resources
- For provider use only; members should contact the customer service number on the back of their ID card

A direct line to member triage

Calls to Customer Service involving complex cases are seamlessly transferred to our clinical triage team through a warm handoff process. Additionally, **providers seeking assistance with behavioral health care coordination may call the triage line directly: 1 (877) 336-8251.**

The triage line is not intended for claims or provider network questions.

The triage line serves as a central resource for anyone seeking behavioral health support—whether they're members, family members or providers—and can typically resolve needs on a single phone call.

The triage team offers comprehensive support tailored to individual needs:

- Assesses immediate needs and identifies crisis resources when necessary
- Matches members with appropriate levels of care based on clinical needs and preferences
- Facilitates connections to in-network providers and virtual care options
- Coordinates access to support programs and community resources
- Assists health care providers with patient care coordination

Additional resources

We recognize that patients may struggle to find behavioral health providers who are both accepting patients and the right fit for their needs. Seeing a virtual provider can make it easier for members to find timely care with providers whose expertise matches their needs.

We strive to simplify behavioral health care access across all entry points. You can find in-network virtual providers in the Telehealth section of our [Behavioral Health Toolkit](#), available on the homepage of our provider website.

Behavioral health HEDIS measure changes and takeaways

Supporting patients through critical care transitions is a vital pillar of providing excellent care.

In 2026, we are prioritizing three behavioral health measures that PCPs can influence to improve patient outcomes while managing utilization and cost of care. NCQA continues to refine HEDIS® measures by expanding the denominator to include more patients, as well as making it easier to close gaps.

Follow-Up After Hospitalization for Mental Illness (FUH)

[FUH](#) underwent significant updates in 2025.

- Diagnoses changes: The measure now includes phobia, anxiety and additional intentional self-harm diagnoses to the denominator, expanding the scope of patients who qualify for this measure.
 - Intentional self-harm diagnoses can now appear anywhere on the acute inpatient discharge claim, not just as the primary diagnosis, which means more hospitalizations will qualify.
- Services: A wider range of services can now close gaps in this measure.
 - Peer support and residential treatment services now count as valid follow-up care.
- A mental health disorder diagnosis during the follow-up visit continues to be required for all follow-up with non-behavioral health professionals. This gives you more flexibility while still ensuring patients get follow-up care within 7 days of discharge.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

[FUI](#) mirrors the FUH change. Beginning in 2026:

- Substance use disorder (SUD) diagnoses can appear in any position on the follow-up claim instead of only the primary position.
- Peer support services were added to the expanded numerator criteria as a new way to close gaps.

These changes expand your options for meeting quality benchmarks, especially for follow-up measures with limited windows to act.

Initiation and Engagement of Substance Use Disorder Treatment (IET)

[IET](#) has not had any significant changes in the past two years, but it remains a highly complex measure requiring both treatment initiation and two additional instances of treatment engagement following a new SUD diagnosis.

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.