JUNE 2025

Provider News

For participating physicians, other health care professionals and facilities

In this issue

New behavioral health triage line

Providers now have a direct line to our behavioral health triage team. We've also improved the member experience by dedicating additional resources to help match them with providers who align with their needs and benefits coverage.

Clinical records to be due at admission

Beginning September 1, 2025, we will require clinical documentation within 24 hours of medical inpatient admission. The simplest way to meet this requirement is to ensure records are visible via electronic medical record (EMR) at the time of admission.

Working together to create equal opportunities for wellness

We believe all people should have an equal opportunity to achieve wellness as part of a health care system that prioritizes diversity, equity and inclusion. View resources for working with diverse populations.

Connect your patients to convenient care options

To help your patients save time and money, we encourage you to help them plan ahead for the next time they need sudden medical care. Learn about our members' care options.

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.

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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.

Administrative Manual updates

The following updates were made to the Facility Guidelines section of our manual:

- **Effective June 1, 2025**: Updated the list of home health codes eligible for reimbursement to align with the current reimbursement schedule
- **Effective September 1, 2025**: Updating that clinical records will be required within 24 hours of medical inpatient admission

Our manual sections are available on our provider website: Library>Administrative Manual.

Phone numbers and addresses

As a reminder, the Contact Us section of our provider website includes links to helpful resources and a list of our current phone numbers and addresses. Please be sure to check this section to ensure you have up-to-date 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 trainings 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 that the entity is 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

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.

Pre-authorization updates

Procedure/medical policy	Added codes effective April 1, 2025
Electromagnetic Navigation Bronchoscopy (Surgery #179)	- C8005
Myoelectric Prosthetic and Orthotic Components for the Upper Limb (Durable Medical Equipment #80)	- L6700
Procedure/medical policy	**Adding codes effective August 1, 2025**
Augmentative Communication Devices and Systems (Durable Medical Equipment #52)	- E2500, E2502, E2504, E2506, E2508, E2510-E2512
Power Wheelchairs: Group 2 and Group 3 (Durable Medical Equipment #37)	- K0820-K0831, K0835-K0843
Spinal Orthoses: Thoracic-Lumbar-Sacral (TLSO), Lumbar-Sacral (LSO), and Lumbar (Durable Medical Equipment #97)	- L0452, L0454, L0456, L0460, L0466, L0468, L0480, L0482, L0484, L0486, L0626, L0627, L0629-L0634, L0636-L0640
Procedure/medical policy	**Adding codes effective September 1, 2025**
Patient Lifts and Seat Lifts (Durable Medical Equipment #23)	- E0625, E0627, E0629, E0630, E0635, E0636, E0639, E0640, E1035, E1036

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.

Access to clinical records to be due at time of admission notification

Beginning September 1, 2025, we will require clinical documentation within 24 hours of medical inpatient admission. This time frame coincides with our inpatient admission notification requirements.

This change affects medical inpatient admissions for all lines of business.

Ensure records are accessible or submitted

Notification requirements aren't changing. However, we will no longer provide a deadline for clinical records when acknowledging admission notification. Instead, records will be required within 24 hours of medical admission, regardless of the type of admission (i.e., elective, urgent/emergent and neonatal intensive care unit [NICU]).

- **Facilities that use PointClickCare (PCC) and grant EMR access will not experience a change in process.**
- **Change for faxed clinical records**: Providers that have not given BridgeSpan EMR access will need to fax records within 24 hours of admission. **Note**: Faxes should include all clinical records; the face sheet and/or admission diagnosis alone are not sufficient.

If facilities do not submit clinical records within 24 hours of admission, the admission will be administratively denied as provider liability.

Set up EMR access today

Ensuring BridgeSpan members are visible to the health plan via EMR at the time of admission helps avoid delays in review and administrative denials.

- We are building out new functionality around use of EMRs. Providers that allow us to integrate into their EMR will have a more automated experience with decreased review times.
- Granting access to your EMR reduces the time and resources your staff dedicates to record retrieval. Contact your provider relations executive to learn more about connecting your EMR.
- Our clinical team is experienced with multiple EMR systems and extensively trained annually on HIPAA and EMR systems.
- We retrieve only the minimum records necessary.

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 May 1, 2025

- Enteral therapy in the home setting
    - Administration fees for enteral therapy charges will be denied when drugs did not receive pre-authorization for Individual members subject to our *Enteral and Oral Nutrition in the Home Setting* (Allied Health #5) medical policy.

Pre-pay edits effective June 1, 2025

- Add-on code billed without base code
- CMS Status I codes

Pre-pay edit effective June 27, 2025

- Capped rentals (CR) or transcutaneous electrical nerve stimulators (TENS) billed with modifiers NU (new equipment) and RR (rented monthly) for the same code and by the same provider
    - This edit is also supported by our *DME Purchase and Rental Limitations* (Administrative #131) commercial and Medicare Advantage reimbursement policies.

Pre-pay edit effective July 27, 2025

- Therapy service modifiers and frequency

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.

Medication policy updates

Effective May 1, 2025, we will make changes to the following medication policy:

- Trodelvy, sacituzumab govitecan-hziy, dru645

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

- Site of Care Review, dru408

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

- Blood Factors for Hemophilia A, High-Cost Extended-Half-Life (EHL) Products, dru549
- Blood Factors for Hemophilia B, Extended-Half-Life (EHL) Products, dru550
- Complement Inhibitors, dru385

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.

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 90-day notice in the April 2025 issue of *The Bulletin* about changes to the following medical policies, which are effective July 1, 2025:

- *Air Ambulance Transport* (Utilization Management #13)
- *Electromagnetic Navigation Bronchoscopy* (Surgery #179)
- *Knee Surgeries* (Surgery #229)
- *Negative Pressure Wound Therapy in the Outpatient Setting* (Durable Medical Equipment #42)

We provided 90-day notice in the May 2025 issue of *The Bulletin* about changes to the following medical policies, which are effective August 1, 2025:

- *Augmentative Communication Devices and Systems* (Durable Medical Equipment #52)
- *Power Wheelchairs: Group 2 and Group 3* (Durable Medical Equipment #37)
- *Spinal Orthoses: Thoracic-Lumbar-Sacral (TLSO), Lumbar-Sacral (LSO), and Lumbar* (Durable Medical Equipment #97)
- *Testosterone Testing* (Laboratory #81)

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

Reimbursement policy updates

We provided 90-day notice in the April 2025 issue of *The Bulletin* about changes to our *Sepsis* (Facility #120) reimbursement policy, which are effective July 1, 2025.

No changes to reimbursement policies in the May 2025 issue of *The Bulletin* required advance notice.

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

MCG guideline updates

MCG revises its proprietary guidelines annually. We will implement the 2025 guidelines beginning in late June. Updated criteria are available in Availity Essentials.

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.

New behavioral health triage line

Through our new behavioral health navigation and triage line, we're transforming how we support members seeking care.

A direct line to member triage

Our new, dedicated 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

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

Highlighting available resources

While we've expanded our network, many of our virtual care options remain underutilized, and members still struggle to find providers who are both accepting patients and the right fit for their needs. As part of our broader strategy to simplify behavioral health care access across all entry points, our Customer Service team recently received in-depth training about available services, including virtual care options and other valuable resources.

Throughout 2025, we will continue enhancing our website and app navigation to help members independently find behavioral health care that aligns with their needs and benefits coverage.

In-network virtual providers are also listed in the Telehealth section of our Behavioral Health Toolkit, available on the homepage of our provider website.

Get reimbursed for integrated care and e-consults

PCPs frequently treat patients with behavioral health needs, particularly those with mild to moderate conditions. However, some patients require specialized care beyond what PCPs can typically provide because of limited clinical expertise or resources.

These two approaches are effective at supporting PCPs in delivering comprehensive behavioral health services:

- Integrating behavioral health providers in primary care settings using the Collaborative Care Model (CoCM)
- Using psychiatric electronic consultations (e-consults)

For both CoCM and e-consults, PCPs should first obtain informed consent from their patients and notify the patient that they may be responsible for their cost share (e.g., copay, coinsurance or deductible).

Integrated, collaborative care

The American Psychiatric Association (APA) recognizes CoCM as the behavioral health integration model with the strongest evidence for "effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes and increasing patient satisfaction" across diverse primary care settings. **We encourage providers to participate in the CoCM approach to treat and support members with complex needs.**

The model consists of a team of three individuals delivering care: A PCP, a behavioral health care manager and a psychiatric consultant. Integrated behavioral health services may include:

- Counseling
- Medication support
- Care planning for behavioral health conditions
- Ongoing assessment of the patient's condition
- Other recommended treatment, if needed

Key elements

- Care coordination by a behavioral health care manager or psychiatric consultant working alongside the PCP
- Regular treatment and monitoring with standardized outcome measures based on targeted quality outcomes
- Regular caseload review with a psychiatrist who provides treatment recommendations

We reimburse:

- Behavioral health services provided in the primary care setting
- CoCM codes CPT 99492-99494 and HCPCS G2214

Resources

- **Reimbursement policy**: Review our *Collaborative Care Codes* (Behavioral Health #100) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.
- **CMS**: The *Behavioral Health Integration Services* booklet explains care team roles, CoCM components and code descriptions.
- **APA**: Learn about the CoCM model, including reducing care inequities and CoCM training for PCPs, behavioral health care managers and psychiatrists.

E-consults

E-consults help address challenges PCPs face when treating complex medical and behavioral health conditions by providing timely access to specialty expertise. **We recognize the value of timely access to specialty consultations and reimburse PCPs and consulting specialists.**

E-consults are asynchronous provider-to-provider consultations conducted through shared EMR systems or web platforms. PCPs request expert consultation on clinical issues, and specialists review records and provide written consultation reports.

These visits allow timely specialist advice, especially for providers who don't otherwise have access to psychiatrists in their community.

Specialty e-consults can:

- Address medication-related issues
- Provide evaluation and management (E&M) recommendations
- Clarify diagnostic considerations
- Determine whether in-person care is urgently needed

We reimburse:

- The treating PCP for CPT 99354-99359 and 99452
- The consulting specialist for CPT 99446-99449 and 99451

Resource

- American Medical Association (AMA): Learn about *what e-consults can do for your patients—and your practice*.

Working together to create equal opportunities for wellness

We believe all people should have an equal opportunity to achieve wellness as part of a health care system that prioritizes diversity, equity and inclusion. We recognize that 80% of health outcomes are driven by non-clinical factors, which is why our commitment to whole-person support is essential to addressing health disparities.

Provider directory information

Our Find a Doctor tool includes information to help our members connect with providers they feel best meet their health care needs and individual preferences. The demographics and areas of interest in our provider directory include:

- Languages spoken
- Pronouns
- Gender identity
- Race and ethnicity
- Culturally specific care
- LGBTQ+-inclusive care
- Disability-competent care

Resources for working with diverse populations

Culture, language, customs, personal beliefs and experiences all impact how patients participate in their health care.

Our Health Equity Toolkit, available on the homepage of our provider website, provides essential resources to help you support patients with unique needs or preferences. This online library connects you to:

- National standards for culturally sensitive care
- Resources for working with diverse populations
- Continuing medical education courses
- Health literacy tools
- Social determinants of health codes
- Interpreter services information

Social need screening and intervention

The Healthcare Effectiveness Data and Information Set (HEDIS®) measure Social Need Screening and Intervention (SNS-E) measures the number of patients screened for food, housing and transportation needs and, among those who screened positive, how many received an appropriate intervention. The National Committee for Quality Assurance (NCQA) allows the use of a variety of evidence-based, validated screening instruments. They also recommend that detailed assessment of these social needs be documented in medical records to support evidence-based interventions.

More information on this measure is included in our *Quality Measures Guide*, available on our provider website: Programs>Quality Incentive.

Together, we can advance diversity, equity and inclusion in the communities we serve.

Quality in Action articles

The Quality in Action section on our provider website is an extension to this publication.

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

- Maximizing the impact of well-child visits
- Prioritizing women's health
- Test result follow-up processes impact patient satisfaction
- **Behavioral health**: Help increase rates of post-discharge care

QIP updates

We want to inform you that the details for our 2025 Quality Incentive Program (QIP) continue to be delayed. We understand this may impact your planning efforts and appreciate your patience.

What you should know

- We are actively working to finalize program specifications
- Care gaps for 2025 remain accessible in your CGMA dashboard
- The opt-in deadline for the 2025 program is June 30, 2025

We will notify providers as soon as the complete program information becomes available through:

- CGMA Monday Morning emails
- Our provider website
- Direct communications to your QIP primary contact

QIP 2024 payout

We expect to mail checks for any earned incentives for the 2024 program year by June 30, 2025.

Payout disputes

If you have any questions or concerns about your 2024 program performance or payout, please email us by July 31, 2025. We will review your dispute and will contact you to determine next steps and resolution.

Connect your patients to convenient care options

To help your patients save time and money, we encourage you to help them plan ahead for the next time they need sudden medical care.

Recent studies indicate that approximately 30% of emergency department (ED) visits could be handled in alternative care settings. Unnecessary ED visits not only increase health care costs but can also result in:

- Longer wait times for all patients
- Higher out-of-pocket expenses for your patients
- Potential exposure to other illnesses in crowded waiting rooms
- Reduced continuity of care

Resources for providers

The Care Options Toolkit on the homepage of our provider website includes:

- Information for providers about members' care options, including virtual medical and specialized behavioral health providers, our 24/7 nurse line, urgent care and more.
- A member FAQ with information about virtual, in-person (including urgent care centers) and emergency care.

Resources for our members

We continue to educate our members about their care options to ensure that they are receiving the care they need in a setting that's clinically appropriate and most cost-effective. By signing in to their bridgespanhealth.com account, members can find:

- Provider and pharmacy directories
- Immediate care options, including nearby urgent care clinics and emergency rooms
- Virtual care options, including scheduling doctor's appointments, asking a pharmacist and behavioral health support
    - If you offer telehealth services, share information with your patients about how they can schedule a virtual appointment with you. To indicate whether you offer telehealth services, update your directory information on our provider website: Contact Us>Update Your Information.
- In-home care urgent medical care with DispatchHealth
    - With DispatchHealth, your patients can skip the wait at the ER and get high-quality urgent medical care at home. They can treat many urgent health conditions, just like an urgent care clinic—and for a similar cost. Patients can book a same-day appointment any day of the year.
    - They are available in the Portland, Oregon; Seattle, Spokane, Tacoma, Olympia and Vashon Island, Washington; and Salt Lake City, Utah, areas.

Our members can also call the Customer Service number on the back of their member ID card for help with finding care, including registering for a bridgespanhealth.com account and navigating to the Find Care section.

How you can help guide appropriate care utilization

- During regular visits, educate your patients about when to use each care option and encourage them to visit our member website for more information.
- Provide after-hours guidance in your voicemail messages about appropriate care options.
- Consider sharing information about DispatchHealth information with your patient (if available in the patient's area).
- Remind patients that true emergencies (e.g., chest pain, stroke symptoms, severe bleeding) still warrant immediate 911 calls.

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.