APRIL 2026

Provider News

For participating physicians, other health care professionals and facilities

In this issue

Inpatient hospital admissions and notifications moving to electronic submission

Beginning July 1, 2026, inpatient hospital admissions, notifications and related clinical records must be submitted electronically.

Hysterectomy site-of-care reviews

We will review the site of care for select hysterectomy diagnosis and procedure codes when a provider seeks to perform the surgery in an outpatient hospital setting on or after July 1, 2026. We do not review the site of care for services performed at an ambulatory surgical center (ASC).

Expectations for correct coding

As part of our ongoing commitment to operational integrity, industry-standard billing practices and cost stewardship, we expect providers to follow correct coding guidelines.

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 ● Radiology
▲ Cardiology ★ Stars Ratings/Quality

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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 *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 April 1, 2026:

Appeals for Providers

- Updated process for submitting appeals

Complementary & Integrative Care

- Updated section name; section was previously titled Alternative Care

We will publish the following updates to our manual on May 1, 2026:

Medical Management

- Updating period in which providers may request a medical peer-to-peer review

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

NICU records requirements

We began requiring clinical documentation within 24 hours of medical inpatient admission in 2025 for all types of admission. **Effective May 1, 2026**: Neonatal intensive care unit (NICU) stays will be administratively denied as provider liability if clinical records are not received within 24 hours of admission.

This requirement aligns with the 24 hours allowed for inpatient admission notification.

Correct coding and claim edits

Accurate coding is essential to ensuring consistent, timely and appropriate claims processing. As part of our ongoing commitment to operational integrity, industry-standard billing practices and cost stewardship, we expect providers to follow correct coding guidelines to:

- Support accurate and timely reimbursement
- Reduce administrative burden for providers and payers
- Maintain alignment with national coding standards and payer policies

When we identify claims that deviate from coding standards, we apply correct coding edits to comply with standards and policies that providers are expected to follow.

We may implement new edits to enforce correct coding without advance notice because:

- They enforce coding and reimbursement rules providers are already obligated to follow
- Do not reflect a change to our requirements

The importance of correct coding editors

Coding editors help support accurate claims payment and prevent avoidable rework for providers and health plans. By denying claims that are incorrectly coded, we ensure billing accuracy, support policy compliance and prevent payment of services that do not meet coding requirements.

Correct coding editors identify billing patterns that conflict with established guidelines, including but not limited to:

- CPT/HCPCS code definitions
- ICD10 diagnosis requirements
- Industry standards
- Our reimbursement policies

Our pre-pay and post-service editors:

- Enforce existing coding or reimbursement rules that are already in effect
- Are supported by existing policies, industry coding manuals and administrative reimbursement guidelines
- Apply industry-supported reviews

Examples of incorrect coding commonly addressed through coding edits include but are not limited to:

- Billing professional services on facility claims or vice versa
- Duplicate billing
- Improper modifier usage
- Missing required diagnoses
- Unbundling of services

For more information

View our *Correct Coding Guidelines* (Administrative #129) policy and other reimbursement policies in the *Reimbursement Policy Manual* on our provider website: Policies & Guidelines>Reimbursement Policy.

Submit inpatient hospital notifications and records electronically

Fax submissions for inpatient notifications and clinical records will be discontinued in the future. To avoid disruptions, facilities should begin submitting electronically beginning in July this year.

- **Availity Essentials**: Submit acute inpatient hospital notifications and clinical records supporting admission reviews and continued stay reviews. When appropriate, some requests may receive immediate approval, reducing follow-up and administrative burden.
- **PointClickCare (PCC)**: Inpatient hospital admission notifications received via PCC are treated as a request for review if you provide us with access to your electronic medical record (EMR). If you do not provide access to your EMR, requests for review should be made via Availity Essentials.
- **EMR**: We can retrieve clinical records if access has been granted.
- **Fax**: In the future, accepted only for approved exceptions.

Facilities that are:

- Not already using Availity Essentials should register for free today.
- Submitting by fax should transition to electronic submission now to avoid disruption.
- Using PCC must ensure EMR access is granted so records can be retrieved electronically.

Training and resources

Find training on Availity Essentials: Help & Training>Get Trained, then search for **Authorization Request (New) - Training Demo**.

Site-of-care reviews being added for hysterectomies

Effective July 1, 2026, we will review the site of care when a provider seeks to perform a hysterectomy in an outpatient hospital setting for select diagnoses.

Hysterectomies may still be performed in an outpatient hospital setting if:

- Clinical criteria are met or
- An in-network ambulatory surgical center (ASC) is not available locally

We announced changes to our medical policies in the April 2026 issue of *The Bulletin*, available on our provider website: Library>Bulletins.

The policies are available in the *Medical Policy Manual* on our provider website: Library>Policies & Guidelines>Medical Policy.

- The *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19) policy will include the diagnosis and procedure codes that will require site-of-care review. **Related**: See *Pre-authorization updates* on page 6.
- The *Hysterectomy* (Surgery #218) policy will indicate the diagnosis and procedure codes we will review for medical necessity.

Site-of-care reviews

We assess the site of care for select services to determine whether a lower level of care is appropriate.

- **Setting**: We only review the site of care when a surgery is scheduled in an outpatient hospital setting. We do not require site-of-care review for services performed at an ASC or physician office.
  - A site-of-care pre-authorization denial is not a denial of services; it is only a denial of the requested outpatient hospital setting.
  - Procedures requiring inpatient stays are subject to concurrent review to determine the appropriate length of stay.
- **Other considerations**: We consider an individual's health status, facility and geographic availability, specialty requirements, physician privileges and other factors when determining the appropriate site of care.

Submitting pre-authorization requests

Providers should submit pre-authorization requests through Availity Essentials' Electronic Authorization application.

We recognize fax submissions may be necessary to ensure care is not delayed when an extenuating circumstance prevents them from submitting a request via Availity. Faxed requests must meet exception criteria and include:

- The *Provider Fax Submission Exception Form*
  - Use this fax coversheet to indicate the reason for the fax exception.
- The *Surgical Site of Care Additional Information Form*
  - Use this form to identify why performing the surgery in an outpatient hospital setting is medically necessary

These forms are available on our Pre-authorization list.

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 February 2026 issue of *The Bulletin* about changes to our *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19) medical policy, which will be effective May 1, 2026.

We provided 90-day notice in the March 2026 issue of *The Bulletin* about changes to our *Cryosurgical Ablation of Miscellaneous Solid Tumors Outside of the Liver* (Surgery #132) medical policy, which will be effective June 1, 2026.

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

No reimbursement policies in the February and March 2026 issues of *The Bulletin* required advance notice.

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

Pre-authorization updates

Procedure/medical policy	Added codes effective March 1, 2026
Artificial Intervertebral Disc (Surgery #127)	- 22857, 22860, 22862, 22865, 0164T, 0165T, 0719T
Procedure/medical policy	**Added codes effective April 1, 2026**
Gastroesophageal Reflux Surgery (Surgery #186)	- 43820
Genetic Testing; Lynch Syndrome and APC-associated and MUTYH-associated Polyposis Syndromes (Genetic Testing #06)	- 81435
Procedure/medical policy	**Adding codes effective July 1, 2026**
Cardiology—Carelon Medical Benefits Management (Carelon)	- 37254-37261, 37263-37278, 37280-37299, 92930, 92945, C7516-C7520, C7568-C7570
Enteral and Oral Nutrition Therapy in the Home Setting (Allied Health #05)	- B4034-B4036, B4081-B4083, B4087, B4088, B9002, B9998, B4105, B4148-B4150, B4152, B4153-B4155, B4157-B4162, S9434, S9435
Hysterectomy (Surgery #218) **Related:** See *Site-of-care reviews being added for hysterectomies* on page 4.	- 58150, 58152, 58180, 58260, 58262, 58267, 58270, 58275, 58280, 58290-58292, 58294, 58541-58544, 58550, 58552-58554, 58570-58573
Radiology—Carelon	- 70472, 70473
Surgical Site of Care – Colonoscopy and Sigmoidoscopy (Utilization Management #20)	- 45330, 45331, 45335, 45338, 45347, 45349, 45350, G0104
Surgical Site of Care - Hospital Outpatient (Utilization Management #19) **Related:** See *Site-of-care reviews being added for hysterectomies* on page 4.	- 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58290-58292, 58294, 58541-58544, 58550, 58552-58554, 58570-58573, 58661

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.

Medication policy updates

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

- *Bruton's Tyrosine Kinase (BTK) Inhibitors*, dru691
- *Drugs for Chronic Inflammatory Diseases, dru444*
- *Medications for Epidermolysis Bullosa*, dru759
- *Venclexta, venetocla*, dru462

Effective September 1, 2026, we will change the following medication policy:

- *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. This content is updated with new required notifications and information about the changes 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.

Quality in Action articles

Are you looking for resources and best practices to support your practice in delivering high-quality, patient-centered care?

The Quality in Action section on our provider website includes materials that 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 content 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:** *Get reimbursed for integrated care*
- *Cancer screenings and prevention*
- *Improving members' experience with medications*
- *Resources for addressing social determinants of health*
- *Taking control of tomorrow: National Healthcare Decisions Day*
- *Tobacco cessation resources for providers*

Chronic Conditions Assessment Program (CCAP) launches

CCAP rewards participating PCPs for accurate coding and complete, consistent documentation of chronic conditions. Eligible provider groups that close the minimum threshold of risk adjustment suspected and persistent diagnosis gaps are eligible to earn an incentive for each attributed/assigned member with a chronic condition.

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

Opt-in to the program

Your Quality Incentive Program (QIP) primary contact 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 the CGMA through Novillus LLC.

Note: Claim gap closures will display fully by May 1, 2026.

Important upcoming dates and deadlines

- **Complete CGMA user audit by May 31, 2026**: Novillus audits CGMA users to confirm appropriate access to protected health information (PHI). Your QIP primary contact will be prompted to confirm your CGMA user access list.
- **Opt-in by June 30, 2026**: To be eligible for this program, your QIP Primary Contact will need to opt in by June 30, 2026. If you're an alternative payment model (APM) provider, your enrollment is automatic. You will be opted in to all programs you are eligible for.

More information

We recently updated the information about this program on our provider website: Programs>CCAP.

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.

Virtual addiction treatment now available to Idaho members

As the demand for mental health support continues to rise, access to and availability of timely, high-quality care remains one of the biggest challenges members face. Virtual providers can help meet that demand—often with shorter wait times.

Virtual addiction and substance use disorder (SUD) provider Eleanor Health has been available to members in Washington state and recently joined our Idaho network.

About Eleanor Health

Through integrated, evidence-based outpatient care, the addiction treatment addresses all aspects of patients' wellness and health as they relate to addiction, including:

- Mental health concerns, including serious and persistent mental illness (SPMI) and other co-occurring disorders
- Physical health conditions
- Accessing community resources

The whole-person, wraparound care model for both rural and urban members includes a focus on reducing barriers to high-quality, effective addiction treatment.

Eleanor Health provides the following services to members 18 and older:

- Medication-assisted treatment (MAT)
- Therapy
- Psychiatry
- Peer support
- Nursing care management
- Community support services
- Care coordination for physical or social needs

Help members find virtual behavioral health care

These virtual providers—and more—are listed in the In-Network Providers section of our Behavioral Health Toolkit, available on the homepage of our provider website. The toolkit also includes information about many resources and tools available to PCPs and behavioral health providers.

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.