OCTOBER 2025

Provider News

For participating physicians, other health care professionals and facilities

In this issue

2026 product and network updates

Each year, we conduct a comprehensive review of our provider networks and product offerings to ensure we serve our members' diverse health care needs and deliver high-quality, cost-effective health care solutions.

2026 brings code changes for services and supplies

Please remember to review your 2026 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

Enforcement of deadlines for requested records

Our *Timely Receipt of Medical Records* (Administrative #145) reimbursement policy will be updated clarify that incomplete requests and records received after the 90-day period will not be accepted and will not change the adjudication of the claim. Providers will need to follow the dispute process to have records reviewed after the 90-day deadline.

Change to colonoscopy site-of-care exceptions

Effective January 1, 2026, providers will no longer be able to cite a lack of ambulatory surgical center (ASC) privileges when requesting to perform a screening or surveillance colonoscopy in an outpatient hospital setting. These reviews will be subject to our new *Surgical Site of Care – Colonoscopy* (Utilization Management #20) commercial medical policy.

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.

Correct coding updates

Claims received on or after November 7, 2025

Providers are expected to follow correct coding guidelines. We are providing courtesy notice that our pre-pay correct coding editors will apply denials for claims received on or after November 7, 2025, for incorrect reporting in the following circumstances:

- A diagnosis that requires an additional diagnosis is missing from claims data (e.g., a diagnosis of hypertensive retinopathy requires both an ICD-10 code for the eye condition and a separate code for the underlying systemic hypertension)
- Durable medical equipment requiring a rental or purchase modifier is billed without the appropriate modifier
- Modifier 59 is appended to services when no other non-evaluation & management (E&M) services are reported on the same date of service by the same provider
- Modifier XS is reported with an anatomic modifier on the same line
- Repeat genetic testing is billed for disorders that can only be tested once in a patient's lifetime

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

Claims in process on or after February 1, 2026

Claims will be reviewed by a new third-pass pre-payment editor that supports our medical and reimbursement policies. The editor will review provider-submitted claims to reduce post-payment recoveries.

- Types of affected claims include:
- Inpatient and outpatient professional
- Inpatient and outpatient facility
- Inpatient and outpatient hospital

The editor will not affect claims-processing times or the appeals process.

2026 brings code changes for services and supplies

Please remember to review your 2026 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

- **CDT manual**: Available online through the American Dental Association or by calling 1 (800) 947-4746
- **CPT and HCPCS manuals**: Available through your preferred vendor or online through the American Medical Association (AMA)

Access current reimbursement schedules on Availity Essentials: Claims & Payments> Fee Schedule Listing.

This notice serves as an Amendment to your Participating Agreement. You have the right to terminate your Agreement in accordance with the amendment provisions of the Participating Agreement.

Administrative Manual updates

The following updates were made to our manual on October 1, 2025:

Facility Guidelines

- Added a link to skilled nursing facility (SNF) claim accuracy tips and best practices, available on our provider website: Claims & Payment>Claims Submission>Other Billing Information
- Streamlined the information about extenuating circumstances

Medical Records Requirements

- Clarified requirements and added tips and examples for retrieving accurate signature information from electronic medical records (EMRs)

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

Updates to Part 2 rules for SUD records

In 2024, the U.S. Department of Health and Human Services (HHS) updated the Part 2 rules that protect the confidentiality of substance use disorder (SUD) patient records.

Providers and payers are expected to be in compliance with the updated regulations by February 16, 2026.

Updates include:

- A new sample consent form—titled *Consent for Disclosure of Patient Identifying Information and Substance Use Disorder Patient Records*—has been added to our provider website:
  - Library>Forms
  - Claims & Payment>Claims Submission>Other Billing Information
- Part 2 disclaimer language, which is required on Part 2 claims, has been updated on our provider website: Claims & Payment>Claims Submission>Other Billing Information. The disclaimer language is prescribed by rule.

Part 2 rule changes are already in effect, and providers should begin using the newly updated consent guidelines and Part 2 disclaimer as soon as possible and by no later than February 16, 2026.

Provider write-off for medical necessity denials

As a reminder, in the August 2025 issue of this newsletter, we announced that providers must write off services we have denied because they do not meet medical necessity, as well as any other services related to the denial, effective November 1, 2025. The provider cannot balance bill the member for services that do not meet medical necessity.

If a member elects to receive services that are not medically necessary, the member may accept financial responsibility by signing a waiver that meets certain requirements. A sample non-covered services waiver form is available on our provider website: Library>Forms.

Pre-authorization updates

Procedure/medical policy	Added codes effective September 1, 2025
eviCore Spine - Interspinous and Interlaminar Stabilization and Distraction Devices (Spacers) (Surgery #155)	22867, 22868
Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders (Surgery #221)	0569T, 0570T, 0646T
Procedure/medical policy	**Added codes effective October 1, 2025**
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	Q4391
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	0585U
Radiofrequency and Ultrasound Ablation of the Renal Sympathetic Nerves as a Treatment for Uncontrolled Hypertension (Surgery #235)	0338T, 0339T, 0935T, C1735, C1736
Procedure/medical policy	**Changing applied policy beginning January 1, 2026**
Surgical Site of Care – Colonoscopy (Utilization Management #20) **Related**: See *Colonoscopy site-of-care exception changing* on page 6.	44388, 44389, 44391, 44392, 44394, 44408, 45378, 45379, 45380-45382, 45384-45386, 45388, 45389, 45390-45393, 45398, G0105, G0121

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.

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 August 2025 issue of *The Bulletin* about changes to the *Extravascular (Substernal) Implantable Cardioverter-Defibrillator* (Surgery #17) medical policy, which are effective November 1, 2025

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

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 August and September 2025 issues of *The Bulletin* required 90-day notice.

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

Updates to timely records policy

When we request records to support claims/ reimbursement, providers have 90 calendar days to submit them. **Effective January 1, 2026**: We will no longer accept requested records after the 90-day deadline. Providing records after this deadline will not change adjudication of the claim.

This requirement applies to clinical records, as well as financial records (i.e., itemizations and invoices) that aren't available by EMR.

Impact to providers

- To have records reviewed after the 90-day deadline, providers will need to follow the dispute process as stated in section 1.4 of the Appeals for Providers section of our *Administrative Manual*, available on the home page of our provider website.
- Failure to submit timely records may result in claims denied as provider liability. Providers cannot balance bill members for provider liability denials.

More information

- Review the *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines>Reimbursement Policy.
- We announced updates to our *Timely Receipt of Medical Records* (Administrative #145) reimbursement policy in the October 2025 issue of *The Bulletin*, available on our provider website: Library>Bulletins.

Colonoscopy site-of-care exception changing

Effective January 1, 2026, providers will no longer be able to cite a lack of ambulatory surgical center (ASC) privileges when requesting to perform a screening or surveillance colonoscopy in an outpatient hospital setting.

Colonoscopies performed in an outpatient hospital setting already require pre-authorization for commercial members. We announced in the October 2025 issue of *The Bulletin* that we will begin reviewing these procedures under a new medical policy: *Surgical Site of Care – Colonoscopy* (Utilization Management #20). **Related**: See *Pre-authorization updates* on page 4.

Under this policy, providers may continue to perform diagnostic colonoscopies in an outpatient hospital setting if:

- Clinical criteria are met, and
- The provider lacks ASC privileges, or an in-network ASC is not available locally

Site-of-care reviews

We assess the site of care for select services to determine whether the requested location is appropriate. This ensures care is delivered in the most appropriate and cost-effective setting. Our reviews consider an individual's health status, facility and geographic availability, specialty requirements and other relevant factors.

Notes:

- We currently review colonoscopies under our *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19) medical policy.
- A site-of-care pre-authorization denial is not a denial of services; it is only a denial of the requested outpatient hospital setting.
- Blank forms will not be accepted and will be voided.

Save time and effort with Availity

For the fastest review, submit requests through Availity Essentials' Electronic Authorization application. Some requests will receive automated approvals. The Availity process incorporates additional questions related to site of care, so you don't need to complete and submit attestation-based supporting documentation.

For colonoscopies performed on or after January 1, 2026, faxed pre-authorization requests must include the new *Surgical Site of Care (Colonoscopy) Additional Information Form*, which will be available on our provider website in December. **Failure to submit a completed and signed form will delay review**.

More information

Review these resources on our provider website:

- The new policy in our *Medical Policy Manual*: Library>Policies & Guidelines>Medical Policy
- The policy announcement in the October 1, 2025, issue of *The Bulletin*: Library>Bulletins
- **Coming soon**: Additional information in the December 2025 issue of this newsletter

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 mental health provider Rula

As the demand for mental health support continues to rise, availability of timely, high-quality care remains one of the biggest challenges members face.

Access to mental health services is critical. Members who want to begin therapy often give up trying to find care, and when they do find a therapist, most wait more than 30 days for their first appointment.

Rula, a virtual-forward provider group, helps meet those demands by providing fast, personalized access to mental health care, matching 98% of patients with a provider who meets their unique clinical and personal preferences (e.g., specialty, gender, language, ethnicity).

Rula offers:

- **Speed to care**: Rula's platform lets members book a virtual therapy appointment in less than 3 minutes. Appointments are available with a licensed provider in as little as 24 hours.
- **Network size**: Rula's network includes more than 18,000 therapists and psychiatric providers across 90+ specialties and diverse backgrounds.
- **Services offered**
  - Therapy for individuals (ages 5 and up), families and couples
  - Medication management (ages 13 and up)

Rula is featured in the In-Network Providers section of our Behavioral Health Toolkit, available on the homepage of our provider website. The toolkit includes information about many resources and tools available to PCPs and behavioral health providers.

Medication policy updates

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

- *Drugs for Chronic Inflammatory Diseases (Standard Plus Formulary)*, dru444
- *Enzyme Replacement Therapy*, dru426
- *Medications for Hereditary Angioedema*, dru535
- *Medications for Epidermolysis Bullosa*, dru759
- *Non-Preferred Blood Glucose Test Strips and Blood Glucose Meters*, dru505
- *Non-Preferred Drugs*, dru760
- *Products with Therapeutically Equivalent Biosimilars/ Reference Products*, dru620
- *Site of Care review*, dru408
- *Synagis, palivizumab, Respiratory syncytial virus (RSV) immune prophylaxis*, dru029
- *Yondelis, trabectedin*, dru440

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.

2026 updates to Washington state Essential Health Benefits

Washington state has announced significant updates to its Essential Health Benefits (EHB) that will take effect on January 1, 2026. The 2026 updates include modifications to the following benefit areas.

- **Acupuncture**—Visit limits removed
- **Artificial insemination**—New coverage for qualifying plans limited to simple preparation (sperm washing and isolation) and placement of sperm into cervix or uterus to achieve pregnancy.
- **Neurodevelopmental/habilitative/rehabilitative support**—Enhanced flexibility
  - **Note**: When someone with a neurodevelopmental diagnosis uses all their neurodevelopmental therapy benefits, they will be able to start charging that same therapy against their rehabilitative benefits and then their habilitative benefits. If you have questions about your patients' benefits after checking Availity Essentials, contact the Provider Contact Center.
- **Hearing instruments and services**—Expanded coverage
- **Inpatient donor breast milk**—Added to maternity benefits
- **Foot care and pediatric dental**—Language clarifications

Effective January 1, 2026, you can verify your patients' updated benefits using Availity Essentials.

2026 products and networks

Each year, we conduct a comprehensive review of our provider networks and product offerings to ensure we serve our members' diverse health care needs and deliver high-quality, cost-effective health care solutions. As part of this process, we also implement changes to comply with Affordable Care Act (ACA) requirements and state and federal mandates.

Below is an overview of the changes to our product portfolio for 2026.

Our product portfolio will include exclusive provider organization (EPO) products in Oregon, Utah and Washington. EPO members only have in-network benefits, and members will be responsible for 100% of out-of-network costs except:

- Out-of-network emergency room, ambulance services and urgent care will be covered at the in-network benefit level. Urgent care services may be subject to balance billing.
- When traveling out of our service area, urgent care, emergency room and ambulance services are covered with no balance billing if the member sees a participating MultiPlan provider.

The open enrollment period for individuals in Oregon, Utah and Washington seeking coverage beginning on January 1, 2026, will be November 1, 2025, through January 15, 2026

Individuals may qualify for special enrollment periods outside of this period if they experience certain life events. Members whose plans are being discontinued have received notice from us about options available to them in 2026.

Provider networks and products

New Individual Value network:

- Supports on-exchange members in Oregon, Utah and Washington and members who travel to Idaho
- **Idaho network area**: Ada, Bannock, Bear Lake, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Butte, Canyon, Caribou, Camas, Cassia, Clark, Clearwater, Elmore, Franklin, Fremont, Gem, Gooding, Idaho, Jefferson, Kootenai, Latah, Lewis, Lincoln, Madison, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Valley and Washington counties
- **Oregon network service and sales area**: Statewide
- **Utah network service and sales area**: Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Juab, Morgan, Rich, Salt Lake, Summit, Tooele, Uintah, Utah and Weber counties
- **Washington network and sales service area**: Benton, Clark, Columbia, Franklin, King, Kitsap, Klickitat, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla and Yakima counties; Note: The Washington Healthplan Finder includes Cascade Select plans (public option plans that are not available through BridgeSpan) and Cascade Care plans (that are available through payers, including BridgeSpan). If you are part of the Individual Value network in Washington, you are in-network for the corresponding Cascade Care plan.

Benefit highlights

- In addition to having access to telehealth services from in-network providers, members will have access to telehealth services for urgent care and behavioral health through the national telehealth provider Doctor on Demand.
- Most members will have access nurse triage lines (depending on their plan), available 24/7.
- Bump2Baby℠ maternity management program is available to support parents-to-be.

Verify network participation

Verify your network participation and find other in-network providers using our provider search tool on our website.

Verify eligibility and benefits

You can verify your patients' eligibility and benefits on Availity Essentials.

More information

Information about our 2026 products is available in the Products and Networks section of our provider website.

Verify your network participation for 2026 to ensure members can continue in-network care

We are introducing a new Individual Value network for our Individual and family plans in 2026. To ensure your patients continue to receive in-network services, please verify your participation in the new Individual Value provider network and refer patients to in-network providers. You can find 2026 in-network Individual Value providers using our provider search tool, available on our website. We are sending letters to members with their 2026 network and plan options.

If you need help finding an in-network provider for your patient, please contact the Provider Contact Center.

FreeStyle Libre discontinuations

Abbott is discontinuing FreeStyle Libre 2 and FreeStyle Libre 3 continuous glucose monitor sensors by September 30, 2025, replacing them with the Freestyle Libre 2 Plus and FreeStyle Libre 3 Plus sensors.

The Plus sensors:

- Are still compatible with the existing smartphone apps and readers
- Have extended wear time, up to 15 days
- Are compatible with selected insulin pumps
- Are suitable for ages 2 and up

You will need to submit new prescriptions for your patients to transition to the Plus sensors. Learn more about the FreeStyle Libre transition for prescribers.

Preferred diabetes supply manufacturer change

Starting January 1, 2026, we are changing our preferred manufacturer of diabetes supplies and will stop covering LifeScan products in retail and home delivery pharmacies. We will cover Ascensia or Abbott products on all lines of business.

How this affects your patients

Members will need to switch to products from Ascensia or Abbott when they need a new glucometer or test strips on or after January 1, 2026. We are notifying members of the steps they should take for this transition, including any coupon codes that they can use to reduce costs.

What you should do

- Start prescribing Ascensia or Abbott glucometers and test strips now for patients who are new to treatment.
- Be prepared to issue new prescriptions on or after January 1, 2026, for patients who use a LifeScan product so they can easily switch to the new products.

Quality in Action articles

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

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

- *Closing the gap in early breast cancer detection*
- *Screening for behavioral health conditions in primary care*
- *The importance of medication reviews*

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.