June 2026 Third Party Changes of Significance

MISSISSIPPI MEDICAID

Reprocessing Claims for Vision Services Due to Fee Update Error. DOM LateBreaking News. May 29, 2026

"Effective July 1, 2021, vision service fees were to remain in effect the same as those effective for State Fiscal Year (SFY) 2021. These fees were erroneously updated and will be corrected to reflect fees that were in effect for SFY 21.

Claims beginning with dates of service on or after July 1, 2023, will be reprocessed for the codes listed below. The reprocessed claims will appear on future remittance advices (RAs).

92002 92004 92012 92014 92015 92018 92019 92020 92025 92060 92071 92072 92081 92082 92083 92100 92132 92133 92134 92136 92201 92202 92230 92235 92240 92242 92250 92260 92265 92270 92273 92274 92283 92284 92285 92286 92287 92310 92311 92312 92313 92325 92326 92340 92341 92342 92352 92353 92354 92355 92358 92371"

https://medicaid.ms.gov/late-breaking-news/

Passive Enrollment Transition. DOM LateBreaking News. May 22, 2026

"Passive Enrollment became effective October 1, 2025, which allowed new MSCAN members to become enrolled in a managed care plan immediately. Previously, MSCAN members had a waiting period of 30 days in Fee-for-Service (FFS) before being enrolled with a managed care plan.

With the transition to Passive Enrollment, some members may have erroneously been transitioned from FFS to Managed Care or enrolled in Managed Care with the wrong effective date. The Division of Medicaid is working to resolve these issues. Once resolved, these members may transition back to FFS and the CCO will recoup payment of claims for members who transition back to FFS.

Per the Administrative Code under Part 200, Chapter 1, Rule 1.6 – Timely Filing, claims that were originally submitted to and paid by a Coordinated Care Organization (CCO), but are later recouped by the CCO due to a retroactive change in the beneficiary's enrollment from the CCO to Fee-for-Service (FFS), must be submitted to the Division of Medicaid within:

1. Three hundred sixty-five (365) calendar days from the date of service; or
2. Within Ninety (90) calendar days of the CCO recoupment, if the CCO recoupment date is after the timely filing period of three hundred sixty-five (365) calendar days from the date of service

Administrative Reviews for Timely Filing should be submitted at Timely Filing Review Request. When submitting your request for an administrative review for timely filing, be sure to:

- Include a formal letter;
- Clearly explain the timely filing issue;
- Provide justification;
- Attach all required documentation; and
- Reference applicable Administrative Code rules. See https://medicaid.ms.gov/providers/administrative-code.

Incomplete submissions will be returned without action if the required documentation is not provided."

https://medicaid.ms.gov/late-breaking-news/

New Virtual Assistant Available for Medicaid Provider Services Calls. DOM LateBreaking News. May 18, 2026

"Beginning June 1, 2026, the Mississippi Division of Medicaid (DOM), in collaboration with Gainwell Technologies, will launch GABBY™, a new Virtual Agent designed to improve the provider call center experience and make it easier for providers to access information.

GABBY uses voice recognition to understand a caller's request and direct them to the appropriate self service options—eliminating the need to navigate multiple menu layers.

Through the virtual agent, providers will be able to access information such as:

• Member eligibility
• Claim status
• Check amounts
• Provider enrollment
• Prior authorization status

If GABBY cannot resolve the request, callers may choose to be transferred to a live representative for additional support.

To ensure the best experience, providers are encouraged to have their MESA Provider ID or NPI ready when calling.

Additional details about the virtual agent are available in the following fact sheet.

GABBY Virtual Agent Fact Sheet"

https://medicaid.ms.gov/late-breaking-news/

Reminder: Review and Update Your Provider Directory Information. DOM LateBreaking News. June 25, 2026

"Provider information collected during enrollment, recredentialing, and revalidation must be updated whenever changes occur through the MESA Provider Portal. To maintain an accurate Mississippi Medicaid Provider Directory, providers are required to review and validate their directory information at least every 90 days.

Please review and update, as applicable:

- Office hours
- ADA accessibility accommodations at servicing locations
- Telehealth availability
- Digital contact information (endpoints)
- Electronic prescribing capabilities
- Referral requirements
- Acceptance of new patients
- Languages spoken

Updating Your Information in MESA

1. Log in to the MESA Provider Portal.
2. Navigate to Characteristics to review and update location details.
3. Review and update service location information in the Addresses section.
4. Review and update language information in the Languages section.

Need Assistance

Contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or your designated Provider Field Representative for assistance with reviewing and submitting updates through the Provider Portal."

https://medicaid.ms.gov/late-breaking-news/

CMS, NOVITAS, RAILROAD MEDICARE

New Medicare Cards Arriving for Some. Medicare Advocacy. June 11, 2026

"According to some news sources, roughly 1.3 million Medicare beneficiaries began receiving new Medicare cards in March, 2026. Recently, beneficiaries have contacted CMA and other advocates due to receiving new cards. The Centers for Medicare and Medicaid Services (CMS) did not issue a detailed explanation for this wave of new Medicare numbers and cards, but it is likely linked to previous security breaches and fraudulent activity…."

https://medicareadvocacy.org/new-medicare-cards-2026/

Noridian Educational Experience (NEE). Noridian. June 26, 2026

"Noridian is pleased to re-introduce the Noridian Educational Experience (NEE), a modern, centralized platform designed to enhance provider education through interactive, self-paced training modules. **As part of this transition, existing YouTube tutorials are being phased out in favor of a more streamlined and comprehensive learning experience.**

NEE offers a growing library of courses and structured curriculums covering key Medicare topics. Many courses are eligible for Continuing Education Unit (CEU) credits, supporting ongoing professional development while improving compliance and operational efficiency.

Access to NEE has been expanded, and registration requirements have been simplified, allowing more providers and suppliers to enroll and begin training quickly.

New content is added regularly based on feedback. After completing each course, participants are encouraged to share input on improvements and future topics to ensure education remains relevant, practical, and aligned with provider/supplier needs.

We encourage all to register and explore the available training opportunities: Register for NEE

If you have questions regarding NEE, please contact noridianedexsupport@noridian.com.

Thank you for your continued partnership and commitment to accurate and compliant Medicare billing."

https://noridianexternal.myabsorb.com/#/signup-form

Top Time-Saving Tools for Railroad Medicare Providers. Railroad Medicare – Palmetto GBA. June 3, 2026

"Are you aware that Palmetto GBA Railroad Medicare provides comprehensive tools to assist you in accomplishing a variety of tasks in order to save you time and streamline your processes? Calling our Provider Call Center (PCC) isn't the only way to receive immediate assistance from Railroad Medicare. Here are the top tools available to providers designed to streamline communication and enhance your productivity. Please review this updated article and share it with your staff."

https://palmettogba.com/rr/did/gd9h2wek6d?cat=rr-customer-service#ls

Federal Rule Takes Aim at Health Care Bureaucracy, Reducing Dispute Fees & Boosting Transparency. CMS MLN Connects Newsletter. June 4, 2026

"Major reforms were finalized to strengthen the No Surprises Act by making the Federal Independent Dispute Resolution process more efficient and transparent, while also saving money for millions of Americans. The final rule improves the process used to resolve out-of-network payment disputes between providers and payers—cutting administrative costs and improving how disputes are handled.

More Information:

- Full press release
- Final rule
- Fact sheet"

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-june-4-2026#_Toc231460168

DME: Complying with Proof of Delivery Requirements. CMS MLN Newsletter. June 4, 2026

"The Comprehensive Error Rate Testing (CERT) Task Force identified missing or incomplete proof of delivery (POD) documents for DME claims. You're required to maintain POD documentation for 7 years from the date of service regardless of your delivery method.

Use the POD Requirements (PDF) work guide to learn what you must include and what's required for each delivery method.

More Information:

- Standard Documentation Requirements for All Claims Submitted to DME MACs article

- Medicare Program Integrity Manual, Chapter 4 (PDF), section 4.7.3.1.1–4.7.3.1.3
- CERT webpage

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-june-4-2026#_Toc231460168

National Correct Coding Initiative: July Update. CMS MLN Newsletter. June 4, 2026

RHW: No code changes impacting Optometry in this update but all providers should review.

> "Get the National Correct Coding Initiative (NCCI) first quarter edit files effective July 1, 2026, on these Medicare NCCI webpages:
>
> - Procedure-to-Procedure Edits
> - Medically Unlikely Edits
> - Add-on Code Edits"

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-june-4-2026#_Toc231460168

Need a Refresher? 'Cognitive Assessment and Care Plan Services' Module Is Here to Help! Railroad Medicare - Palmetto GBA. June 28, 2026

> "Do you need to refresh your knowledge on Medicare's coverage for cognitive assessment and care plan services? Don't miss out on the opportunity to review Palmetto GBA's Cognitive Assessment and Care Plan Services module where you'll discover a helpful and insightful overview. Please review and share with appropriate staff."

https://palmettogba.com/jjb/did/6qc5kbnpst#ls

CMS Provider Minute: The Importance of Proper Documentation Video. CMS. June 25, 2026

> "This CMS video will help providers and physicians understand the need and importance of medical record documentation to support the services billed. Watch this video to learn more about what the CERT program has identified as leading documentation errors, and what providers and physicians can do to more thoroughly document the patient's medical record. Please share with appropriate staff."

https://www.youtube.com/watch?v=hG9fefmKUR0

House Appropriations Committee Takes Aim at CMS' WISeR Pilot. MedPage Today. June 10, 2026

> "The House Appropriations Committee voted to bar CMS from spending funds on the controversial WISeR pilot program, which introduces prior authorization for certain procedures in traditional Medicare."

https://www.fiercehealthcare.com/regulatory/house-appropriations-committee-takes-aim-cms-wiser-pilot

RRB Top Medical Review Denials Module: Q3 2025. Railroad Medicare – Palmetto GBA. June 11, 2026

> "The goal of Palmetto GBA's Railroad Retirement Board Specialty Medicare Administrative Contractor (RRB SMAC) medical review program is to ensure that payment is only made for services that meet all Medicare coverage, coding and medical necessity requirements. Please review the most common provider errors in the third quarter of 2025. Please review this information and share it with your staff"

https://palmettogba.com/rr/did/vtytq88vwk#ls

2026 MIPS Value Pathway (MVP) Registration Open. QPP. June 17, 2026

> "The Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) registration window is open for the 2026 performance year. Individuals, groups, subgroups, and Alternative Payment Model (APM) Entities that wish to report an MVP can register **until November 30, 2026, at 8 p.m. ET.**
>
> To register, you'll sign in to the QPP website with your HCQIS Access and Roles Profile (HARP) account.
>
> You must have a HARP account and a QPP Security Official role to complete the MVP Registration.

- For more information on HARP accounts, please refer to the Register for a HARP Account document in the QPP Access User Guide (ZIP, 5MB).
- For more information on obtaining the QPP Security Official role, review the Connect to an Organization document in the QPP Access User Guide (ZIP, 5MB).

Prepare for MVP Registration

Before you register, you'll need to have the following items identified:

- The MVP you plan to report
- Whether you plan to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey, if it's a quality measure option in your selected MVP
- Whether you want to be evaluated on an outcomes-based administrative claims quality measure, if it's a quality measure option in your selected MVP
- The participation option you plan to use individual, group, subgroup, or APM Entity

Additional Information for Group Registration

Starting in 2026, to register for MVP reporting as a group, your practice will need to attest to their specialty composition (whether you're a single specialty group or multispecialty small practice) during the MVP registration process. We won't make this determination for you. All other groups will need to participate as subgroups or as individuals (if eligible) to report an MVP.

A single specialty group means a group that consists of clinicians in one specialty type, or clinicians in more than one specialty type with a single clinical focus of care. For example, a group consisting of internists, cardiologists, nurse practitioners, and physician assistants that are focused on providing cardiovascular care could attest to being a single specialty group and register to report an MVP as a group.

How to Register

Individuals, groups, subgroups and APM Entities will register on the QPP website. You'll need to have the Security Official role to register your organization. Please refer to the QPP Access User Guide (ZIP, 5MB) for information about obtaining a Security Official role for your organization. To register: Sign in to QPP

- Click **Register** or **edit an MVP registration** from the landing page
- Click your MVP reporting option

Note: If the CAHPS for MIPS Survey is included in your chosen MVP and you plan to use it as one of your four required measures, you must complete both your MVP registration and a separate CAHPS for MIPS Survey registration by June 30, 2026, at 8 p.m. ET. Visit the QPP website for details on registering for the CAHPS for MIPS Survey.

Additional Resources

- 2026 MVP Registration Guide (PDF, 2MB)
- 2026 MVPs Implementation Guide (PDF, 3MB)
- 2026 Explore MVPs "

Understanding Telehealth Enrollment Guide. CMS MLN Connects. June 25, 2026

"Not sure how to enroll for telehealth services? Our Understanding Telehealth Enrollment (PDF) guide breaks down everything you need to know to enroll correctly."

https://www.cms.gov/files/document/understanding-telehealth-enrollment.pdf

Need a Refresher? 'EDI Enrollment Instructions Guide' Module Is Here to Help!. Railroad Medicare-Palmetto GBA. June 24, 2026

"Do you need help on completing the Electronic Data Interchange (EDI) Enrollment packet? Don't miss out on this opportunity to gain some helpful tips. Our 'EDI Enrollment Instructions Guide' module is here to help! Please review this module and share it with your staff."

https://api-prod.palmettogba.com/h/elearn/rrbedienroll/story.html

OTHER

6 insurers Exiting ACA Markets. Jakob Emerson. Beaker's Payer Issues. June 12, 2026

"Six insurers have announced they will stop offering ACA marketplace plans, either nationally or in specific states, after the 2026 plan year. …

Six updates:

1. **Cigna** is exiting the exchange in Arizona, Colorado, Florida, Georgia, Illinois, Indiana, Mississippi, North Carolina, Tennessee, Texas and Virginia, affecting about 369,000 members. …"

https://www.beckerspayer.com/payer/aca/6-insurers-exiting-aca-markets/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

Ambetter and Medicare Request for Medical Records. Magnolia Health Weekly News Blast. June 26, 2026

Magnolia Health is committed to improving the quality of care provided to our members. We are required by the U.S. Department of Health & Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), in accordance with Risk Adjustment guidelines, to submit complete diagnostic data regarding you patients, our Wellcare and Ambetter members. We do so by facilitating medical record reviews.

It is our obligation to ensure accurate and complete data is sent to federal (and, where applicable, state) regulators. Although the request for medical records is not an audit, our intention is to ensure we are aligned with our regulators for complete data accuracies.

We thank you for your participation in prior reviews and want to provide an overview of the programs that will take place over the next 12 months.

Program Logistics

	Wellcare	Ambetter
Members	MA, MMP, and DSNP Members with 2025 visits	Members with 2026 visits
Records Needed	Dates of service/encounters from January 2025 through present day	Dates of service/encounters from January 1, 2026 through December 31, 2026
Timeline for Active Outreach	June through December 2026	September 2026 through April 2027; incremental records may be requested after the initial, for the complete encounter year
Outreach Vendors	We contract with several vendors to obtain records on our behalf. You may receive outreach from Datavant, Advantmed, Datafied, Virtix, or others.	
Turn Around Time to Submit Medical Records	Outreach vendors will request the fulfillment of records within a business week. However, special accommodations can be considered.	
NOT AN AUDIT!	While we do need these records to submit diagnostic data to HHS, CMS, and state agencies, this should not be considered an audit or a claims denial exercise.	

Options for Submitting Records

Vendor: We engage several vendors to conduct reviews. A vendor representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered.

Electronic Records: Let us make it easier for you to deliver records! Our team will be happy to help reduce your administrative burden by retrieving records directly from your system. If interested in providing Magnolia Health with access to your EMR system, please complete the form in this link. https://forms.office.com/r/r9hzCxU4qR

If you've already established interoperability with us, we will work to obtain the records directly.

Third Party Vendors: If you work with a third-party vendor for fulfillment of charts, please let us know in the form, so we can direct release of information requests appropriately.

Work with Us Directly: Please contact Magnolia Health for options to obtain a request list and send records directly to the health plan.

Start Now

We can obtain charts directly from your EMR. To utilize this service, complete the form and our team will begin the process to establish access.

Become familiar with the Risk Adjustment review process. Scan the QR Code below for Frequently Asked Questions regarding our record request program.

https://mailchi.mp/e626f170cc3e/pooscgsvfh-59972?e=6d63e1c4a4

Aetna: Clinical Policy Bulletin (CPB) 1093: Remote Physiologic Monitoring #1091. May 31, 2026

"This CPB has been updated with additional coding."

https://www.aetna.com/cpb/medical/data/1000_1099/1093.html

Aetna: Clinical Policy Billeting (CPB) 0023: Corneal Remodeling [Cross-linking]. June 23, 2026

"This CPB has been revised with the following changes to the medical necessity criteria for collagen cross-linking for keratoconus: (i) to specify epithelium-off photochemical collagen cross-linkage using riboflavin and ultraviolet A (Photrexa 'and Photrexa Viscous') for the treatment of 'progressive' keratoconus and keratectasia 'following refractive surgery'; and (ii) epithelium-on collagen crosslinking using FDA-approved riboflavin with ultraviolet A (Epioxa and Epoioxa HD), (a) to specify use in members 13 years of age and older; and (b) to add selection requirements."

https://www.aetna.com/cpb/medical/data/1_99/0023.html#dummyLink2

Aetna: Specialty Pharmacy Clinical Policy Bulletins - Miebo, Tryptyr, Xiidra Medical Necessity (ACCF, ACF, Aetna FI ACF, SCCF, SF, VF) 6974-C P11-2025 v2. January 2026

https://www.aetna.com/products/rxnonmedicare/data/2026/Miebo,_Tryptyr,_Xiidra_Medical_Necessity_(ACCF,_ACF,_Aetna_FI_ACF,_SCCF,_SF,_VF)_6974-C_P11-2025_v2.html

Aetna: Medical Clinical Policy Bulletins Number: 0508. Aetna. June 2, 2026

"This CPB has been revised to state that secondary implantation is considered medically necessary following complicated cataract surgery (e.g., dislocated IOL, retained cataract lens fragment removal)."

https://www.aetna.com/cpb/medical/data/500_599/0508.html#dummyLink2

Centene (Commercial, HIM/ICHRA, Medicaid) Clinical Policy: Oxymetazoline (Rhofade, Upneeq) Reference Number: CP.PMN.86. Effective Date: 06.01.19

"2Q 2022 annual review: no significant changes; added 60 g tube and 30 and 60 g pump formulations of Rhofade; references reviewed and updated."

https://portal.policyreporter.com/redirect/email/23388/11a1c01b9f911f07/5428765

Cigna Coverage Policy Number IP0027 Glaucoma Prostaglandins. Cigna Health Care. May 15, 2026

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/pharmacy/ip_0027_coveragepositioncriteria_ophthalmic_prostaglandin_analogs.pdf

Cigna - Ophthalmic – Glaucoma – Prostaglandins Prior Authorization Policy. May 20, 2026

"Zolymbus was added with the same criteria as the existing products within the policy."

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/cnf/cnf_585_coveragepositioncriteria_ophthalmic_prostaglandins_pa.pdf

Cigna: Durysta - Prior Authorization (PA) Form

https://static.cigna.com/assets/chcp/pdf/resourceLibrary/prescription/Durysta.pdf

Cigna: Izervay (Commercial) - Prior Authorization (PA) Form

https://static.cigna.com/assets/chcp/pdf/resourceLibrary/prescription/Izervay.pdf

Cigna: Syfovre (Commercial) - Prior Authorization (PA) Form

https://static.cigna.com/assets/chcp/pdf/resourceLibrary/prescription/Syfovre.pdf

Cigna: Tepezza (Commercial) - Prior Authorization (PA) Form

https://static.cigna.com/assets/chcp/pdf/resourceLibrary/prescription/Tepezza.pdf

Cigna: Dry Eye Disease Cyclosporine Ophthalmic Products. Coverage Policy NumberIP0026. June 15, 2026

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/pharmacy/ip_0026_coveragepositioncriteria_ophthalmic_dry_eye.pdf

Devoted: Eye-wear Following Cataract Surgery [CLMS.CP.0069] 2026-05-04. Devoted. June 5, 2026

RHW: In Mississippi, all Devoted medical claims are sent directly to Devoted following their policies.

https://assets.devoted.com/Claims/Eye-wear_following_Cataract_Surgery

Humana: Allergy Ophthalmic. Step Therapy. Pharmacy Coverage Policy. June 17, 2026

https://portal.policyreporter.com/link/urlupdate/23388/6f78cf056f407b47/415911-5484074.pdf

Humana:Glaucoma Surgical Treatments Policy Number: HUM-1119-007 Effective Date: 06/01/2026

https://dctm.humana.com/Mentor/Web/v.aspx?objectID=090009298a540445

Molina: Eylea (aflibercept) and Biosimilars. Policy Number: C5674-A. April 1, 2026

Notable revisions: Required Medical Information Quantity FDA-Approved Uses References

https://www.molinahealthcare.com/providers/oh/medicaid/policies/-/media/Molina/PublicWebsite/PDF/Providers/oh/medicaid/policies/6-1-26-MHO-UM-C5674-A-Eylea-aflibercept-and-Biosimilars-508.pdf

Language and Interpreter Services: Working with Interpreters in Your Practice. Magnolia Health. June 5, 2026

"Treating the whole patient – not only their conditions – is a major component of delivering quality healthcare. Magnolia Health offers you information and tools to help make that possible. All providers (Medical, Behavioral, Pharmacy, etc.) may request interpreter services, translated materials or auxiliary aids and services. Please call **1-877-236-0751** to speak with provider services. Alternatively, you may also complete the Interpreter Request Form. For in-person interpreter services, the request should be scheduled 5 business days in advance of the appointment to allow time for the vendors to meet the need and coordination of services with the member and provider's office. For urgent needs, we may be able to accommodate services within 2 business days.

When calling in, the following information is required:

- Member Name
- Member ID Number
- Appointment Date and Time

- Language Requested

Cancellation and rescheduling can be completed when necessary.

Not sure of your patient's language? Click on "Language Assistance" in the footer at the bottom of our website and have the member point to their language. If it's not listed, you can work with the interpreter service to identify the right language.

Using the speakerphone function is recommended for communication efficiency between you, your patient and the interpreter.

Providers that use bilingual staff to communicate with patients must ensure that bilingual staff can interpret effectively, accurately, and to and from the language of the patient and English, using any necessary specialized vocabulary terminology and phraseology.

Magnolia Health (Medicaid) members speak more than 15 languages. In 2025, 94.86% of Mississippi residents reported English as their preferred language, and 2.92% prefer Spanish according to U.S. Census data."

https://mailchi.mp/98581807aa53/pooscgsvfh-58883?e=6d63e1c4a4

From CPT Assistant: KB #:8511. Medicine Ophthalmology. 06/03/2026

"Keywords: binocular visionorthoptic therapystrabismusvision therapist

Question: If a physician is unable to directly provide orthoptic therapy, what would be the appropriate code to report when the service is performed by clinical staff or a vision therapist?

Answer: If orthoptic therapy is provided by clinical staff, report code 92066, *Orthoptic training; under supervision of a physician or other qualified health care professional*. Orthoptic therapy is designed to improve binocular vision function and treat strabismus (ie, misalignment of both eyes). The physician prescribes the specific treatment procedures based on an evaluation of the diagnosis and progress made at previous visits. Typically, the patient supplements the in-office treatment at home with prescribed procedures, which are not separately reported. Often, the physician is unable to provide orthoptic training directly to a patient, which is when a clinical staff member would perform the services under the supervision of a physician or other qualified health care professional (QHP). Because of the increased frequency of clinical staff performing orthoptic training services, code changes to differentiate who provided the service were necessary. Hence, in 2023, the descriptor of code 92065, *Orthoptic training*, was revised to "*Orthoptic training; performed by a physician or other qualified health care professional*" to specify that orthoptic training is performed by a physician or other QHP in 2023. In addition, code 92066 was created to enable reporting services performed by clinical staff under supervision of a physician or other QHP. Note that code 92065 may be reported only when the face-to-face portion of the service is performed by a physician or other QHP and may not be reported in conjunction with code 92066. Besides the code revisions, exclusionary parenthetical notes were added to assist in code selection. The changes in 2023 provided more specificity to support accurate reporting of orthoptic training and to better reflect the reality of current clinical practice (ie, clinical staff performing orthoptic training)."

Cultural Competency Training Reminder. Magnolia Health. June 5, 2026

Magnolia requires all providers to complete annual cultural competency training by **December 31st** to comply with CMS, NCQA, and state Medicaid guidelines. This training ensures we deliver equitable, respectful care, improve member communication, and maintain compliance with CMS and the DOM.

Action Required:

- Visit Magnolia Health's Provider Training Page
- Look for the **Cultural Competency** header.
- Complete the training and **submit your attestation** to receive credit.
  (Please do not forget the attestation—it's required for completion!)

If you've taken an approved cultural competency course this year, simply submit the Magnolia attestation to receive credit.

Reminder- The Cultural Competency training is an annual requirement. Please complete by **December 31st.**

If you require assistance locating the training or attestation, please contact your dedicated Provider Engagement Account Manager.

Thank you for your partnership in ensuring compliance and improving care for our members.

https://mailchi.mp/98581807aa53/pooscgsvfh-58883?e=6d63e1c4a4

Alert: Be Aware Of Medicare Advantage Plan Participation Requirements, Referrals. AOA First Look. June 12, 2026

"The AOA is alerting members that we are increasingly observing Medicare Advantage (MA) plans requiring referrals for visits to doctors of optometry, including visits for established patients. It is important to note that some plans specifically exclude doctors of optometry from these referral requirements, so it's critical to remain up to date on plan policies.

In an alert updated May 12, 2026, United Healthcare stated that its new MA referral requirements do not apply to services provided by optometrists.

Verifying referral requirements before a patient visit can help prevent claim denials, payment delays, and other administrative challenges. We encourage members to review plan-specific requirements and, when required, confirm that all necessary referrals have been obtained prior to providing care, even for established patients who have previously been seen by the practice.

It's also important to confirm your practice's participation status with plans. Large payers often offer multiple plan products. It is important to confirm your participation status with each patient's individual plan prior to providing care to help avoid unexpected claim denials and administrative issues.

The AOA will continue its work to advocate for direct access to optometric care to reduce unnecessary barriers to patient care and ensure timely access to services. Please report any issues or health or vision plan challenges to StopPlanAbuses@aoa.org."

AOA's Evidence-Based Clinical Practice Guidelines Offer Care Recommendations. AOA First Look. June 29, 2026

"The AOA's evidence-based clinical practice guidelines offer comprehensive, detailed care recommendations based on the best-available current scientific evidence and research, as well as expert clinical insight, to inform the diagnosis, management and treatment of patients with various eye and vision conditions.

Held to the evidence-based standards set by the National Academies of Sciences, Engineering and Medicine-Health and Medicine Division (NASEM), these guidelines, include:

- Care of the Patient with Primary Open-Angle Glaucoma, First Edition
- Comprehensive Pediatric Eye and Vision Examination, First Edition
- Comprehensive Adult Eye and Vision Examination, Second Edition
- Eye Care of the Patient with Diabetes Mellitus, Second Edition

Additionally, the AOA provides topical, clinical reports available for patient care decision-making, including:

- GLP-1RAs and Ocular Health
- Myopia Management

The AOA also maintains a library of consensus-based clinical practice guidelines.

Learn more about the AOA Evidence-based Optometry Committee's 14-step process, aligned with NASEM, for developing trustworthy clinical practice guidelines. "

Tears: A Well of Diagnostic Info, No Crying Required. Marta Zaraska. Medscape Medical News. June 23, 2026

"…A human tear contains more than 3000 proteins. What if you could tap that information to help diagnose and track disease? …"

Article:https://www.medscape.com/viewarticle/tears-well-diagnostic-info-no-crying-required-2026a1000l9f?ecd=WNL_mdpls_260626_mscpedit_wir_etid8453763&uac=107551EN&spon=17&impID=8453763