

MISSISSIPPI MEDICAID

Provider Off-Cycle Revalidation Overview. DOM LateBreaking News. August 18, 2026

The Mississippi Division of Medicaid (DOM) is conducting off-cycle provider revalidations in accordance with guidance from the Centers for Medicare & Medicaid Services (CMS).

Providers who have not completed revalidation since April 22, 2025, will be required to complete an off-cycle revalidation to maintain compliance with federal enrollment requirements.

To support efficient processing, revalidation notices will be issued in phases over the coming months.

How will providers know when they are scheduled to complete the off-cycle revalidation?

Providers selected for off-cycle revalidation will receive a notification by mail at the mailing address on file with the Division of Medicaid. The notice will include instructions for completing the revalidation process and the required submission deadline.

Important: Providers must submit their revalidation application within 60 days of the date on the notification letter. Failure to complete the revalidation within the required timeframe may affect a provider's Medicaid enrollment.

Providers can also review the Six-Month Revalidation and/or Six-Month Recredentialing Due Lists on the DOM website homepage. In addition, the Provider Search Tool on the DOM website homepage can be used to locate details on individual providers.

How can I confirm the mailing address I have on file?

Providers should verify that the mailing address on file in the MESA Provider Portal is current to ensure receipt of revalidation notices.

To review or update location information, including the mailing address, log in to the MESA Provider Portal and navigate to the Characteristics link.

What should I expect during the revalidation process?

For an overview of the revalidation process, please review the Medicaid Provider Revalidation Roadmap. You can also find more information at <https://medicaid.ms.gov/provider-off-cycle-revalidation-overview/>.

Is there a step-by-step guide for submitting a revalidation application in the MESA Provider Portal?

Yes. Please refer to the Provider Revalidation Guide for detailed instructions on submitting your revalidation application through the MESA Provider Portal.

<https://medicaid.ms.gov/wp-content/uploads/2025/07/Provider-Revalidation-Process-v2.pdf>

How can I stay informed?

Stay informed and up to date by following us on social media.

Sign up to receive email alerts every time DOM posts a Late Breaking News update! Just email a contact name, place of business and a contact number (optional) to LateBreakingNews@medicaid.ms.gov.

Need Assistance?

If you have questions or need assistance reviewing or submitting your revalidation application, contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or your designated Provider Field Representative.

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

Disclosure of Owners and Managing Employees. DOM LateBreaking News. August 11, 2026

"The ownership and managing employee disclosure requirements are a critical component of the initial enrollment, recredentialing, and revalidation application process. Required by federal regulations, these disclosures must be completed accurately and in full.

Providers are also required to keep this information current. Under Mississippi Division of Medicaid Administrative Code Part 200, Chapter 4, Rule 4.8, any changes to ownership or disclosure information, including managing employees, must be reported within 35 days of the change.

Who is considered an owner?

Federal law requires Medicaid providers to disclose every individual or entity with an ownership or control interest.

You must report any individual or organization that meets one or more of the following criteria:

Direct ownership: Owns 5 percent or more of the provider through stock, equity, capital, or profits.

- Indirect ownership: Owns 5 percent or more through another organization that has an ownership interest in the provider.
- Combined ownership: Holds a combination of direct and indirect ownership interests totaling 5 percent or more.
- Secured interests: Holds a 5 percent or greater interest in a mortgage, deed of trust, note, or other obligation secured by the provider, when that interest equals at least 5 percent of the value of the provider's property or assets.
- Corporate officers or directors: Serves as an officer or director of a corporation.
- Partners: Is a partner in an organization that is structured as a partnership.

Note: Ownership does not have to be held directly in your organization. If an individual owns a parent company, holding company, or another organization in the ownership chain, and that ownership results in a 5 percent or greater interest in your organization, that individual must be disclosed.

In addition, corporate officers, directors, and partners must be reported as managing employees even if they do not have an ownership interest.

Who is considered a managing employee?

Federal regulation (42 CFR § 455.101) defines a managing employee as an individual who exercises operational or managerial control over an organization or who conducts its day-to-day operations.

The following non-exhaustive lists positions that typically meet this definition and should generally be reported:

- Chief Executive Officer (CEO)
- President
- Executive Director
- Chief Operating Officer (COO)
- Executive Director of Operations
- Chief Financial Officer (CFO) or Director of Finance
- Regional Director
- Practice Administrator
- Nursing Home Administrator
- Hospice Administrator
- Home Health Administrator
- Operations Manager
- Office Manager
- Clinic Manager
- Clinical Director
- Facility Manager
- An executive of a contracted management company who is responsible for operating the provider
- A management consultant who has contractual authority to direct operations
- Any individual who has significant operational or managerial authority over the organization should be evaluated to determine whether disclosure is required.

Are there special reporting requirements for Skilled Nursing Facilities?

Yes. Skilled Nursing Facilities and other nursing facilities defined under section 1919(a) of the Social Security Act are subject to additional disclosure requirements.

For nursing facilities, the definition of managing employee is broader than the standard federal definition. A managing employee includes any individual, such as a general manager, business manager, administrator, director, or consultant, who directly or indirectly manages, advises, or supervises any part of the facility's clinical practices or service delivery, finances, or operations.

Unlike other provider types, an individual does not have to oversee the entire facility to qualify as a managing employee. Responsibility for advising or supervising a single area may be enough to require disclosure.

Additional disclosures required for nursing facilities

Nursing facilities must report all standard ownership and managing employee information, plus the following:

- Governing body
- Every governing body member, including name, title, and period of service.
- Officers, directors, members, partners, trustees, and managing employees
- Every individual or entity, including name, title, and period of service.
- Additional disclosable parties
- Every individual or entity that meets the federal definition of an additional disclosable party.
- Organizational structure
- The organizational structure of each additional disclosable party.
- Any general partner or limited partner with an ownership interest of 10 percent or more in a limited partnership.

What is an additional disclosable party?

This reporting category applies only to nursing facilities. An additional disclosable party includes any individual or entity that:

- Exercises operational, financial, or managerial control over all or part of the facility.
- Establishes the facility's policies or procedures.
- Provides financial management or cash management services.
- Leases or subleases property to the facility or owns 5 percent or more of the value of that property.
- Provides management, administrative, clinical consulting, accounting, or financial services to the facility.

What if my organization is government-owned or a nonprofit?

If your organization is federally owned, state owned, or a nonprofit without private ownership, you are not required to report an owner. However, you must still disclose all managing employees.

Need Assistance

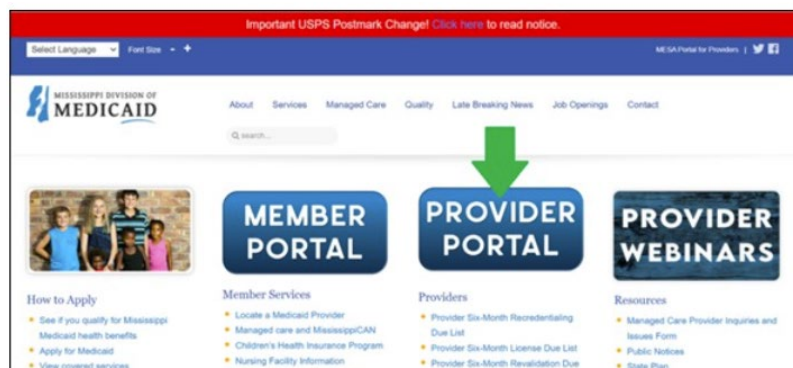
Contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or your designated [Provider Field Representative](#) for assistance with reviewing and submitting updates through the Provider Portal.

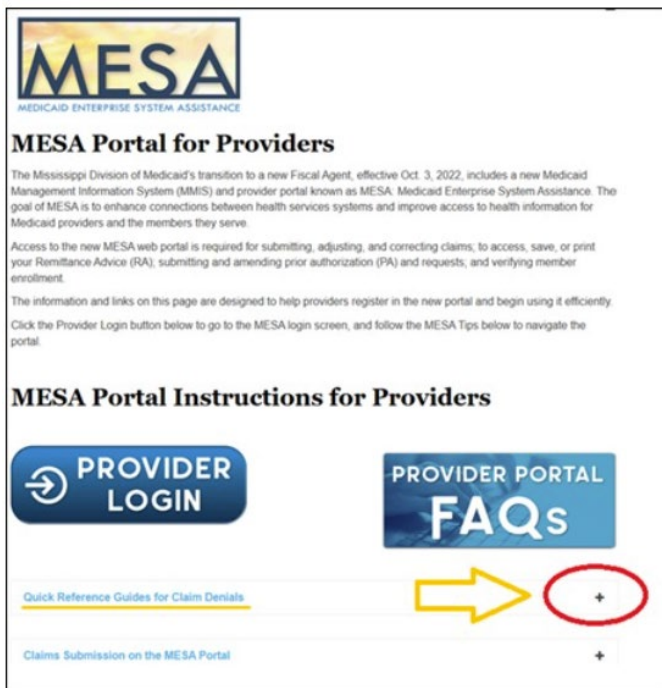
<https://medicaid.ms.gov/late-breaking-news/>

New Training Resources Available Related to Certain Claim Denials. DOM LateBreaking News. July 28, 2026

“The Mississippi Division of Medicaid (DOM) and Gainwell are pleased to announce the development of new training resources to assist providers with understanding and resolving certain claim denials. The new training resources are called Quick Reference Guides (QRGs) and are available as PDF documents with corresponding short training videos. The QRGs and videos are located on DOM’s public website. Follow the navigation prompts below to access the resources.

1. From the DOM [Home](#) page, click on the Provider Portal image.
2. Scroll to **Quick Reference Guides** and click on the + symbol to expand the list.
3. Access the needed QRG documents and/or video links





MESA
MEDICAID ENTERPRISE SYSTEM ASSISTANCE

MESA Portal for Providers

The Mississippi Division of Medicaid's transition to a new Fiscal Agent, effective Oct 3, 2022, includes a new Medicaid Management Information System (MMIS) and provider portal known as MESA, Medicaid Enterprise System Assistance. The goal of MESA is to enhance connections between health services systems and improve access to health information for Medicaid providers and the members they serve.

Access to the new MESA web portal is required for submitting, adjusting, and correcting claims; to access, save, or print your Remittance Advice (RA); submitting and amending prior authorization (PA) and requests; and verifying member enrollment.

The information and links on this page are designed to help providers register in the new portal and begin using it efficiently. Click the Provider Login button below to go to the MESA login screen, and follow the MESA Tips below to navigate the portal.

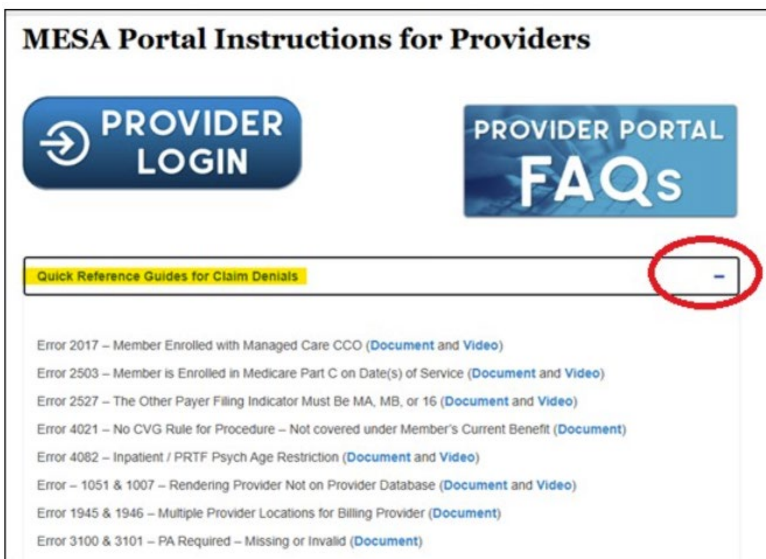
MESA Portal Instructions for Providers

PROVIDER LOGIN

PROVIDER PORTAL FAQs

[Quick Reference Guides for Claim Denials](#)

[Claims Submission on the MESA Portal](#)



MESA Portal Instructions for Providers

PROVIDER LOGIN

PROVIDER PORTAL FAQs

[Quick Reference Guides for Claim Denials](#)

Error 2017 – Member Enrolled with Managed Care CCO ([Document](#) and [Video](#))

Error 2503 – Member is Enrolled in Medicare Part C on Date(s) of Service ([Document](#) and [Video](#))

Error 2527 – The Other Payer Filing Indicator Must Be MA, MB, or 16 ([Document](#) and [Video](#))

Error 4021 – No CVG Rule for Procedure – Not covered under Member's Current Benefit ([Document](#))

Error 4082 – Inpatient / PRTF Psych Age Restriction ([Document](#) and [Video](#))

Error – 1051 & 1007 – Rendering Provider Not on Provider Database ([Document](#) and [Video](#))

Error 1945 & 1946 – Multiple Provider Locations for Billing Provider ([Document](#))

Error 3100 & 3101 – PA Required – Missing or Invalid ([Document](#))

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

Magnolia Health Launches Availity Editing Services (AES) for MSCAN and CHIP Providers. Magnolia Health Weekly News Blast. August 28, 2026

"In a continuous effort to make it easier to do business with us, Magnolia Health is introducing Availity Editing Services (AES) for MSCAN and CHIP. Starting November 15, 2026, Magnolia Health is partnering with Availity to return rejection messages on its behalf via AES messages. These messages will be shown in your existing flows. AES will give you an option, but not a requirement, to edit a claim.

AES can identify a claim error upfront and return a message to you for correction before sending the claim on to the plan to be adjudicated. You should review edit messages for potential corrections to the suggested claim line(s). If you make updates to the claim, this may help the claim process correctly the first time, preventing errors, improving payment accuracy, and claims adjudication turnaround time. If, after reviewing the message, you find it does not apply, please resubmit the claim as-is, and this will allow a bypass of the edit in cases where it may not be applicable.

This is not intended as a new method to deny a claim, nor does it bypass or replace downstream edits. If you choose to bypass an edit, it is possible that other downstream edits will still function as normal in our claims

systems. Remember to “submit” your claim regardless of your choice to edit or bypass. This action is required for the claim to be processed in our systems.

If you have a Practice Management System (PMS), you can locate your edits report within your claims workbasket or queue reporting. If you submit claims via the Availity portal, any of these rejections will show your normal reports.

If you submit claims via Availity, learn how to gather your reporting by joining one of Availity’s free webinars to learn additional tips for streamlining your workflow:

- [Send and Receive EDI Files – Training Demo](#)

This demo shows users where/how they can access reports in Availity Essentials. These reports are where they would see edits. Please note: this demo does not say/call it AES however, this is the demo that would show the user how to locate the reports.

- [EDI Reporting Preferences – Training Demo](#)

This demo shows users how to setup their EDI Reporting Preferences which needs to be done *first* by the user’s organization’s Availity Administrator to access the reports in the Send and Receive EDI Files application.

If you need assistance with registering for Availity Essentials, please call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday, 8 a.m. – 8 p.m. ET. For general questions, please reach out to your Magnolia Health Provider Engagement Representative.”

<https://mailchi.mp/a1a88d6b4aa8/pooscgsvfh-62403?e=6d63e1c4a4>

License Renewal with the Division of Medicaid. DOM LateBreaking News. August 27, 2026

“In compliance with 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) is required to maintain up-to-date licensure documentation for all enrolled providers, including those participating in fee-for-service, MississippiCAN, and CHIP programs.

To prevent deactivation of Medicaid provider numbers and interruption in claims payments, providers must submit current licensure information promptly.

With a high volume of licenses set to expire on or before **December 31, 2026**, it is strongly recommended that providers submit renewed licenses as soon as possible to ensure sufficient processing time and avoid any potential disruptions in payment.

Who Is Affected?

Although this is not an exhaustive list, providers licensed by the following Mississippi state boards may be affected:

- Mississippi State Board of Nursing
- **Mississippi State Board of Optometry**
- Mississippi State Department of Health
- Mississippi Board of Examiners for Licensed Professional Counselors
- Mississippi Board of Examiners for Social Workers and Marriage and Family Therapists
- Mississippi Autism Board

License Expiration Notifications

Providers whose licenses are expiring will receive letters of notification by mail from Gainwell Technologies. As noted in the December 30, 2024, Late Breaking News article, “Letters Available in Provider Portal,” the notification will also be available for viewing in the provider’s portal account.

To stay informed, DOM encourages providers to check the **Provider Six-Month License Due List**, available and updated monthly on the DOM website: [View the Provider License Due List](#)

How to Submit Updated Licenses

Licenses should be submitted electronically via the provider's **MESA Provider Portal**: [Access the MESA Provider Portal](#)

(Use the **Secure Correspondence** feature. A tracking number will be provided upon submission.)

For any assistance required between 8 a.m. and 5 p.m. CST, providers can contact the Provider and Beneficiary Services Call Center at (800) 884-3222.

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

CMS, NOVITAS, RAILROAD MEDICARE

Medicare Sets Payment Rates for Fsyx System. Ophthalmology Management. August 18, 2026

"The Centers for Medicare and Medicaid Services (CMS) has established final 2026 Medicare payment amounts for Balance Ophthalmics's Fsyx Ocular Pressure Adjusting Pump (OPAP) and associated goggles, with the rates taking effect October 1.

Under HCPCS Level II code E2403, the Fsyx pump will be reimbursed as a capped rental at approximately \$1,352.58 per month for months 1 through 3 and \$1,014.44 per month for months 4 through 13. The total capped Medicare payment after 13 months of continuous use is \$14,202.09 per beneficiary. The goggles, assigned HCPCS Level II code A6610, received a fee schedule amount of approximately \$167.99 per unit.

The payment determination follows FDA 510(k) clearance [earlier this year](#) of the wireless-enabled Fsyx system. Balance plans to begin broader commercialization in the fourth quarter of 2026.

Fsyx is a [prescription-only system](#) that uses pressure-modulating goggles and a pump to apply negative pressure to the eyes during sleep. According to Balance, 12 clinical studies involving more than 600 eyes showed a mean 39% reduction in nighttime IOP, with no device-related serious adverse events reported. The system can be used alongside existing glaucoma therapies and transmits patient usage data to the prescribing practice."

https://ophthalmologymanagement.com/news/2026/medicare-sets-payment-rates-for-fsyx-system/?mktId=14597998&md5=b277e9ffd28c8f68d5188b30bb814130&utm_medium=email&utm_source=OMD_ThisWeek_08-20-26&mkt_tok=ODIOLVhPRy0wNTQAAAGjwCmkAbArt9AZyTcLqtB3vuchuBrf6Jrly3E8Nlp-NnrX9QHUFbGZ99o3R4e23Ztz_WIDDQdDBkTJh-YDk_76aTdyxo4XO7WnMjaOI5kx7wajcmCx

New CPT III Codes Effective October 1, 2026. Novitas Solutions. August 26, 2026

1080T Insertion, intracapsular magnifier, with attachment to previously placed intraocular lens

1084T Implantation of scaffolding allograft to reinforce the suprachoroidal space

1090T Attachment and insertion of intraocular lens prosthesis-mounted drug-eluting implant (List separately in addition to code for primary procedure)

1098T Placement of subretinal prosthesis, including vitrectomy

https://www.novitas-solutions.com/cs/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&dDocName=00286783&allowInterrupt=1&IsXml=0

Cruising Through the CERT Claim Review Process. Novitas Solutions. August 25, 2026

"The Comprehensive Error Rate Testing (CERT) program monitors and reports the accuracy of Medicare fee-for-service (FFS) payments. Read this article for helpful information and resources that can help cruise through the CERT claim review process".

<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00203703>

Global Surgery Calculator. Novitas Solutions. August 12, 2026

"Redesigned to provide a faster, more efficient user experience. With improved functionality and performance, users can quickly and confidently determine global surgery periods while increasing productivity."

<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/GlobalSurgeryCalc>

EDI Newsletter. Novitas Solutions. August 1, 2026

"The August 2026 electronic billing newsletter is now available."

<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004731>

Immunizations Save Lives! Railroad Medicare-Palmetto GBA. August 24, 2026

"The Centers for Disease Control (CDC) recommends certain vaccines, including the Tdap, Td, HPV, influenza, and hepatitis B vaccines, for teens and adults based on different age groups. CDC also recommends that adults over the age of 50 receive the shingles vaccine, pneumococcal polysaccharide vaccine, and pneumococcal conjugate vaccine, which protect against serious pneumococcal diseases, including meningitis and pneumonia. Adults need to keep their vaccinations up to date. Immunity from childhood vaccines can wear off over time. Different diseases become risky to adults as well. Know your beneficiaries! Other vaccines may be recommended based on age, health conditions, jobs, lifestyles, or travel plans. People from racial and ethnic minority groups are disproportionately affected when it comes to receiving recommended vaccines. Be aware and discuss concerns about vaccine safety with all groups of beneficiaries. Please review this article and share it with your staff."

<https://palmettogba.com/jjb/did/z2bpz2eu17?cat=jjb-medicare-news>

Top Time-Saving Tools for Railroad Medicare Providers. Railroad Medicare-Palmetto GBA. August 26, 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>

Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices. Railroad Medicare-Palmetto GBA. August 28, 2028

"CMS guidelines mandate the presence of signatures for medical review purposes. However, records pertaining to any procedures billed to Medicare are potentially subject to review by not only Palmetto GBA, but other CMS contractors. Because of this, we are alerting you to the importance of these signature requirements and if changes are needed, we suggest you take immediate action. Please review this updated article and share it with your staff."

<https://palmettogba.com/jjb/did/8eem4q2610?cat=jjb-specialties>

OTHER

Ambetter and Medicare Request for Medical Records. Magnolia Health Weekly News Blast. July 31, 2026

RHW: These are not audits they are Risk Adjustment Record Reviews. Providers may be able to get paid for the time and effort these record requests cost.

AOA links for advice: [Medicare Advantage Risk Adjustment Audits](#) and [Strategic Approach to Medicare Advantage Record Requests](#)

"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.

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.

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.



AOA Resource: Can Aetna Drop Me If I Drop Eyemed?. AOA First Look. August 21, 2026

"Doctors participating in certain Aetna networks should carefully review their contracts for a provision that may link (or tie) the continued participation of the Aetna agreement to a separate EyeMed contract. The AOA developed a member resource for reviewing Aetna contracts to determine whether any tying provision exists and what consequences may result from changes to the EyeMed relationship.

- [Access the resource](#)

If you are interested in learning more about advocating for new state laws regarding anti-tying or any willing provider laws, contact the [AOA's State Government Relations team](#). Doctors may [report challenges](#) with Aetna and EyeMed for AOA experts to review."

Aetna: Fundus Photography Policy 0539. Aetna. August 21, 2026

- **"Updated medical necessity criteria to require that fundus photography is performed only after a dilated fundoscopic exam confirms one of the listed indications.**
- Updated the covered indication from 'diabetes mellitus (diabetic retinopathy)' to 'diabetic retinopathy and/or macular edema'.
- Added a new covered indication: baseline screening evaluation for all members starting long-term hydroxychloroquine or chloroquine therapy, with a note specifying that the baseline ophthalmologic examination should include optical coherence tomography (OCT) and fundus autofluorescence (FAF) (preferably wide-field) where available.
- Updated the experimental/investigational section: replaced 'automated color fundus photography for detection and screening of age-related macular degeneration' with the broader exclusion 'as an exam for screening purposes'; added 'as a screening tool without a dilated fundus exam' to the list of non-covered indications; and removed 'screening in asymptomatic persons without signs or symptoms of disease' from the non-covered sub-list.
- Updated supplementary information.

https://www.aetna.com/cpb/medical/data/500_599/0539.html

Aetna: Dry Eyes – Medical Clinical Policy 0457. Effective October 4, 2026

“This CPB has been revised to state that point-of-care matrix metalloproteinase-9 testing is considered medically necessary to aid in the diagnosis of dry eyes.”

https://www.aetna.com/cpb/medical/data/400_499/0457.html#dummyLink2

BCBS Mississippi: Genetic Testing for Macular Degeneration Policy Number A.2.04.103. BCBS Mississippi.

August 18, 2026

“Genetic testing for macular degeneration is considered investigational.

August 18, 2026: Policy description updated regarding testing for age-related macular degeneration. Policy statement unchanged. Policy Guidelines updated with minor changes.”

<https://www.bcbsms.com/policy-search/medical/policy-detail/genetic-testing-for-macular-degeneration>

Cigna: Drug Coverage Glaucoma Prostaglandins Policy Number IP0027. Effective August 15, 2026

“Employer Plans: Updated the Lumigan preferred product requirements.

Individual and Family Plans: Added new preferred product requirements for bimatoprost 0.01% ophthalmic solution.”

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

March Vision: Unlisted Miscellaneous Codes - Resubmission Requirements. March Vision. August 2026

“Unlisted miscellaneous codes with a rate in the Medicaid fee schedule will now deny “REJCRMISC,” requiring you to resubmit the claim with a justification and documentation for the unlisted miscellaneous service code. Claims will be paid or denied based on the service review.”

<https://view.provideremail.uhc.com/?vawpToken=YJGVFLXJHV6ERNFL65VYZDR56Q.60268>

March Vision: New CE course: Advances in Myopia Management. March Vision. August 2026

“This new COPE-accredited course covers current and emerging approaches to myopia management, including epidemiology, risk factors and myopia progression mechanisms. [Take the course](#)”

<https://view.provideremail.uhc.com/?vawpToken=YJGVFLXJHV6ERNFL65VYZDR56Q.60268>

March Vision: Make The Most of Explanation of Payment (EOP) Statements. March Vision. August 2026

“Our EOP quick reference guide helps you:

- Understand payment summaries
- Track copays, claims and visits
- Enroll in Optum Financial and ECHO Health Inc. for faster payments and convenient EOP access

[Get the Guide](#)”

<https://view.provideremail.uhc.com/?vawpToken=YJGVFLXJHV6ERNFL65VYZDR56Q.60268>

March Vision: Lab Spotlight: Don't forget the Patient-Supplied Frame Letter. March Vision. August 2026

“When submitting an order with a patient-supplied frame, remember to include the Patient-Supplied Frame Letter with the shipment to help avoid processing delays. [Learn More](#)”

<https://view.provideremail.uhc.com/?vawpToken=YJGVFLXJHV6ERNFL65VYZDR56Q.60268>

Centene Ambetter: Clinical Policy: Perfluorohexyloctane (Miebo) Reference Number: CP.PMN.290. Centene August 2026.

“3Q 2026 annual review: no significant changes; added ICHRA line of business; references reviewed and updated.”

<https://www.ambetterhealth.com/content/dam/centene/policies/pharmacy-policies/pmn/CP.PMN.290.pdf>

As States Tighten Oversight, Private Equity’s Healthcare Deals Decline. Anna Claire Vollers. Stateline. August 25, 2026

“States are tightening their regulation of private equity firms, and private equity deals with physician management groups [are expected to drop by nearly half.](#)”

<https://stateline.org/2026/08/25/as-states-tighten-oversight-private-equitys-healthcare-deals-decline/>

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.	

<https://mailchi.mp/3ab6b75c097c/pooscgsvfh-61224?e=6d63e1c4a4>

United Health Care: Brow Ptosis and Eyelid Repair Policy Number: CS008.Z. Effective Date: October 1, 2026

“Coverage Rationale Replaced language indicating “lid retraction surgery (CPT code 67911) is considered reconstructive and medically necessary when all of the [listed] criteria are present” with “lid retraction surgery (CPT code 67911) is considered reconstructive and medically necessary for conditions other than thyroid eye disease when all the [listed] criteria are present”

Thyroid Eye Disease Revised coverage guidelines to indicate lid retraction surgery (CPT code 67911) for thyroid eye disease is considered reconstructive and medically necessary when either of the following criteria are met:

o Moderate to severe disease where all the following apply:

- The disease is stable or inactive, and euthyroidism has been achieved and maintained
- Other causes of lid retraction have been eliminated (e.g., use of dilating eye drops or glaucoma medications)
- There is a functional impairment (e.g., dry eyes, pain/discomfort, tearing, blurred vision)

o Severe, sight-threatening thyroid eye disease (to address subluxation) **Definitions Removed** definition of “Marginal Reflex Distance -1 (MRD-1)”

Supporting Information Updated Clinical Evidence and References sections to reflect the most current information Archived previous policy version CS008.Y”

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/comm-plan/brow-ptosis-eyelid-repair-cs-10012026.pdf>

Humana Xiidra® (lifitegrast ophthalmic solution) Pharmacy Coverage Prior Authorization. Effective July 1, 2026

https://mcp.humana.com/tad/TAD_New/Search.aspx?criteria=xiidra&searchtype=freetext&policyType=both

Humana Medicare Advantage Plans: New Retinal Imaging Benefit. Humana.

RHW: While providers will be required to refund any out-of-pocket costs for patients with this benefit for services between January 1, 2026 and September 1, 2026, this change is expected to impact very few patients per practice.

Per EyeMed: This new benefit will be a smaller subset of all Humana members, only those who have diabetes and Florida is excluded. This is not across the full Humana ecosystem.

On average, there are less than 3 claims over 500 TIN's that will have corrected claims, There are only 30 or so that had 10-34 claims, no independents had more than 34 impacted claims.

"Humana is adding a funded retinal imaging benefit to some Humana Medicare Advantage vision plans

As you know, people living with chronic conditions such as diabetes often benefit from additional support and more coordinated care to help them stay healthy and avoid complications. This is why health plans, such as Humana, proactively connect at-risk individuals with care management programs, outreach, and additional resources.

Effective September 1, 2026, Humana is expanding routine vision care services in some plans to offer a funded retinal imaging benefit for diabetic patients.

The funded retinal image benefit will be retroactive to January 1, 2026. All claims for eligible members who paid out of pocket for retinal imaging between January and September will be reprocessed and you will receive payment to reimburse members for those costs as applicable.

Diabetic members enrolled in these plans will be set up in the system with their core benefit + the funded retinal imaging benefit. You will see this coverage when verifying the member's eligibility. Claim submission processes will remain the same."

Why Are Health Plans Chasing Charts They Already Have?. Steven Berkow. Becker's Payer Issues. July 8, 2026

"CMS expanded RADV audits. Learn how plans can stop chasing charts for risk adjustment"

https://www.beckerspayer.com/payer/why-are-health-plans-chasing-charts-they-already-have/?oly_enc_id=5767J8016534I8J

Epidemic Trend Summary. CDC. August 14, 2026

"In the U.S., COVID infections are [growing or likely growing in 50 states](#), according to the most recent CDC estimates."

<https://www.cdc.gov/cfa-modeling-and-forecasting/rt-estimates/index.html?tab=0>

Prestige Brand Recalls Nearly 40,000 Bottles Of Clear Eyes Maximum Itchy Eye Relief Eye Drops Over Sterility Concerns. AOA First Look. August 24, 2026.

"The [New York Times](#) (8/23, Diaz) reports Prestige Brand Holdings has issued "the voluntarily recall of 39,060 bottles of Clear Eyes Maximum Itchy Eye Relief eye drops because of a 'lack of assurance of sterility,' according to the US Food and Drug Administration." The Class II recall "began on July 29 and is continuing, involves 15-millimeter bottles with a lot code of 2552A and an expiration date of Sept. 30, 2027."

[NBC News](#) (8/21, Weaver) reports, "No other eye drops were included in the recall and no injuries have been reported to date." The eye drops "are sold over the counter nationwide at major retailers, including CVS and Walmart."

Two Recent Fraud Convictions

"Boston-based Ophthalmic Consultants of Boston [agreed](#) to pay nearly \$3.9 million to resolve False Claims Act allegations of improperly billing Medicare and MassHealth for office visits in addition to intravitreal injection procedures."

https://www.beckersasc.com/ophthalmology/massachusetts-ophthalmology-practice-pays-3-9m-to-settle-improper-billing-allegations/?_hstc=77465994.02af02672b2ead5c01e79fdf3f002244.1787254013565.1787254013565.1787254013565.1&_hssc=77465994.2.1787254013565&_hsfp=639666e4eb5eb9ce99342a2cc8bef296

“Two New York ophthalmology practices [agreed](#) to pay a combined \$2.3 million to resolve False Claims Act allegations of billing Medicare and Medicaid for medically unnecessary transcranial Doppler ultrasounds through a kickback arrangement with a third-party testing company. “

https://www.beckersasc.com/asc-coding-billing-and-collections/2-physician-practices-to-pay-2-3m-to-settle-medically-unnecessary-brain-scan-allegations/?_hstc=77465994.02af02672b2ead5c01e79fdf3f002244.1787254013565.1787254013565.1787254013565.1&_hssc=77465994.2.1787254013565&_hsfp=639666e4eb5eb9ce99342a2cc8bef296