

MISSISSIPPI MEDICAID

Provider Disenrollment FAQs. LateBreaking News. Mississippi Medicaid.

“Disenrollment Due to Claims Inactivity

In accordance with provider directory requirements at 42 U.S. Code 1396a, any enrolled Medicaid provider not appearing on a submitted claim within the past 12 months will be disenrolled, effective February 1, 2026. For further details, please see the [Mississippi Administrative Code, Title 23, Part 200, Rule 4.2 \(A\) 17.](#)

My provider enrollment was just approved, what can I do to ensure I am not disenrolled for claim inactivity?

Newly enrolled providers will have up to one (1) year from the effective date of enrollment to appear on a submitted claim before being subject to disenrollment. To prevent disenrollment, providers should submit claims as services are rendered to Medicaid members.

If I have multiple service location enrollments will all locations be disenrolled if only one location does not have any claims activity?

No, only the servicing locations with no claim activity will be disenrolled.

How will I be notified if I am disenrolled?

Each disenrolled provider will receive a notification letter informing them of the disenrollment by mail sent to the mail to address on file with DOM. As noted in the December 30, 2024, Late Breaking News article, the notification will also be available for viewing in the provider portal.

What can I do if I am disenrolled?

Providers disenrolled due to inactivity may submit an application to re-enroll in the Medicaid program at any time. For more information, call the Provider and Beneficiary Services Call Center at 1-800-884-3222 or your designated field representative: https://medicaid.ms.gov/wp-content/uploads/2025/09/Q3-2025-PROVIDER-FIELD-REPRESENTATIVES_Map-and-By-County_v1.0.pdf.”

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

Provider Enrollment Application Fee Increase for 2026. Late Breaking News, Mississippi Medicaid. December 18, 2025

“Effective January 1, 2026, the enrollment application fee for institutional providers will increase from \$730 to \$750 for the 2026 calendar year. Additional details are available in the official federal announcement ([Federal Register](#)).

The application fee applies to the following provider transactions within Medicaid (Fee-for-Service), MSCAN and/or the Children’s Health Insurance Program (CHIP):

- Initial enrollment, reactivation, revalidation, or reenrollment
- Addition of new owners (Change of Ownership)
- Addition of a new Medicaid practice location

Note: Routine updates to provider information—such as changes to phone numbers, bank account details, billing addresses, or provider names—do *not* require payment of the application fee.

To review the list of taxonomies subject to the application fee, please review the DOM [website](#).

Providers submitting their application fee should make their check payable to the Mississippi Division of Medicaid, noting the application tracking number (ATN) on the check and mail it to:

Gainwell Technologies

P.O. Box 6014

Ridgeland, MS 39158.

Providers who have already paid the application fee to Medicare or another state’s Medicaid or CHIP program have fulfilled the requirement and do not need to pay the fee again to Mississippi Medicaid.

For more information, call the Provider and Beneficiary Services Call Center at 1-800-884-3222 or your [designated field representative](#).”

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

Ambetter Health: Billing Code Update for CPT Codes G2211 & G2212. Magnolia Health Weekly News Blast.

January 9 2026

“Effective April 1, 2026 CPT codes G2211 & G2212 will no longer be covered by Ambetter beginning on Apr. 1, 2026.

CPT Code G2211 is an add-on Medicare code used to bill for the complexity of an office or outpatient visit due to the longitudinal and ongoing nature of the practitioner-patient relationship, not the specific condition itself.

CPT code G2212 is an add-on Medicare code used to report prolonged office or other outpatient evaluation and management (E/M) services beyond the maximum time of a primary E/M code. This code is submitted in 15-minute increments.

Providers should continue utilizing E&M codes (i.e., 99202–99205, 99211–99215) as appropriate.

If you have questions about this bulletin or other provider resources, please contact your Provider Relations Representative.”

<https://mailchi.mp/4edbd40eed6f/pooscgsvfh-51673?e=6d63e1c4a4>

Wellcare: Important Prior Authorization Updates. Magnolia Health Weekly News Blast. January 9, 2026

“Effective April 1, 2026 As part of our ongoing work to improve the prior authorization (PA) process for both providers and members, Wellcare wants to share some important updates to our PA requirements. Our goal is to reduce administrative burden, simplify submission and approval processes, and facilitate timely access to appropriate, high-quality care.

Code change details can be found below. These changes may include:

- Removing PA requirements based on criticality of review and clinical need.
- Creating a more uniform set of prior authorization requirements across our markets and lines of businesses, including adding and changing some PA requirements, to simplify processes, reduce confusion for providers, and support future efforts to expand real-time responses to requests.

If you have questions about specific prior authorization codes or how these changes affect your practice, please reach out to your local Provider Engagement representative. “

Service Category	PA Rule	Services	Procedure codes
Vision Services	No PA Required for PAR providers	Vision Evaluation	92004

<https://mailchi.mp/4edbd40eed6f/pooscgsvfh-51673?e=6d63e1c4a4>

CMS, NOVITAS, RAILROAD MEDICARE

Beneficiary Signature Requirements. Palmetto GBA. January 2, 2026

Medicare requires the signature of the beneficiary, or that of his or her representative, for each date of transport, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of death or a mental or physical condition, the individuals listed in this article may sign the claim on behalf of the beneficiary. Please share with appropriate staff.

<https://palmettogba.com/rr/did/8eemj24204#ls>

DMEPOS. Railroad Medicare- Palmetto GBA. January 12, 2025

The January 2026 Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Jurisdiction list of which HCPCS codes are under DME MAC only jurisdiction or dual DME MAC/Part B MAC jurisdiction is now available. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction will be considered to be A/B MAC (Part B) only jurisdiction. This list of the HCPCS codes is updated on an as needed basis (usually quarterly) to reflect codes that have been added or discontinued (deleted) as part of the quarterly HCPCS update. Please share with appropriate staff.

<https://palmettogba.com/rr/did/7gyg851325#ls>

Remote Patient Monitoring: Use & Bill Correctly. CMS MLN Connects. January 15, 2026

“In a [report](#), the Office of the Inspector General recommended additional oversight of remote patient monitoring in Medicare. About 43% of enrollees who received remote patient monitoring didn’t receive all 3 components [education and training, device supply, treatment management], raising questions about whether it’s being used as intended.

Learn how to correctly use and bill for remote patient monitoring:

- [Remote Patient Monitoring](#) webpage
- [Telehealth & Remote Monitoring](#) booklet”

Report: <https://oig.hhs.gov/documents/evaluation/10001/OEI-02-23-00260.pdf>

Providers & Suppliers: CMS Has Authority to Conduct Enrollment Site Visits. CMS MLN Connects. January 15 2026

“CMS conducts authorized enrollment site visits to verify operational status. Site visit inspectors carry a photo ID and CMS-issued letter of authorization that you may review but not retain or copy.

Starting January 3, 2026, 2 new site verification service contractors will conduct these visits:

1. East: Arch Systems, LLC
2. West: Signature Consulting Group

Until February 14, 2026, outgoing contractors may continue performing site visits:

- East: Palmetto GBA and its subcontractors:
 - Overland Solutions, Inc., an affiliate of EXL
 - Information Discovery Services
 - Compliance Review, Inc.
 - National Creditors Connection, Inc.
- West: Deloitte Consulting, LLP and its subcontractors:
 - Nationwide Management Services, Inc.
 - CSI Companies, Inc.
 - Arthur Lawrence Management, LLC
 - Computer Evidence Specialists, LLC”

Evaluation and Management Services & Intravitreal Injections: Bill Correctly. CMS Medlearn Matters. January 22, 2026

RHW: While this OIG report does not directly discuss a procedure that we do, I do think report provides good background and insight into when and why the use of the -25 modifier would be appropriate.

In a [report](#), the Office of the Inspector General found that Medicare providers improperly billed for evaluation and management (E/M) services provided on the same day as intravitreal injections using modifier 25. Only a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure should be separately reported with modifier 25.

Learn when to use modifier 25 to prevent improper payments:

- [E/M Services \(PDF\)](#) booklet
- [Medicare Vision Services \(PDF\)](#) booklet

<https://oig.hhs.gov/documents/audit/10286/A-09-23-03014.pdf>

Quick Reference Guide. Railroad Medicare- Palmetto GBA. January 23, 2026

“The Railroad Medicare Quick Reference Guide is a publication to assist providers with submitting claims to Railroad Medicare. In this guide you can find information about many Railroad Medicare topics, including provider enrollment, submitting electronic and paper claims, using the eServices portal and the Interactive Voice Response (IVR) system, appeals, medical review, Medicare Secondary Payer, overpayments and recoupments, and more. Please share this updated information with appropriate staff.”

<https://palmettogba.com/rr/did/swa6q2cmlz#ls>

FY 2025 Medicare Fee-for-Service Improper Payment Rate. CMS MLN Matters. January 29, 2026

“CMS reported the national Medicare Fee-for-Service (FFS) improper payment rate in the [FY 2025 HHS Agency Financial Report](#) (section 3, Payment Integrity Report).

The 2025 national Medicare FFS improper payment rate is 6.55%, or \$28.83B in improper payments. Most of these improper payments fall into 2 categories:

1. Insufficient documentation
2. Documentation provided didn't sufficiently demonstrate medical necessity

See the [FY 2025 Improper Payments](#) fact sheet for more information.”

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-january-29-2026#_Toc220561060

OTHER

Medicare Telehealth Flexibilities for Wellcare Members Through 2026. Magnolia Health Weekly News Blast. January 9, 2026

“Wellcare Medicare plans will continue to offer expanded telehealth access through 2026 plan years. Our benefits maintain many of the same flexibilities, ensuring no change in telehealth coverage for Wellcare's Medicare members.”

<https://www.wellcare.com/en/providers/medicare-bulletins/telehealth-flexibilities>

How Direct-To-Consumer Health Tests Could Impact Insurance, Mortgages, And Employment. Statnews. January 30, 2026

RHW: Might be good to share with patients!

Health data from direct-to-consumer tests may end up in the hands of insurance companies, mortgage lenders, employers, or law enforcement.

<https://www.statnews.com/2026/01/30/direct-to-consumer-health-tests-face-patient-privacy-questions/>

'Vertical integration Is Destroying People's Ability To Access Care': Payer CEOs Face Bipartisan Congressional Grilling. Jakob Emerson & Elizabeth Casolo. Beckers Payer Issues. January 22, 2026

“'Vertical integration is destroying people's ability to access care': Payer CEOs face bipartisan congressional grilling”

https://www.beckerspayer.com/payer/vertical-integration-is-destroying-peoples-ability-to-access-care-payer-ceos-face-bipartisan-congressional-grilling/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J

Medicare has extended its current telehealth flexibilities through January 30, 2026. At this time, it is unknown whether these flexibilities will be extended further. Regardless of future Medicare decisions, **Wellcare Medicare plans will continue to offer expanded telehealth access through 2026 plan years.** Our benefits maintain many of the same flexibilities, ensuring **no change in telehealth coverage** for Wellcare’s Medicare members.

Current Medicare telehealth flexibilities include:

- Relaxed geographic restrictions
- No originating-site requirements
- Expanded list of eligible telehealth providers

Wellcare Medicare plans will continue these allowances even if Medicare ends its flexibilities:

- Members may receive telehealth services from **any location**—no rural or originating-site limitations.
- **No restrictions** on which types of providers may deliver telehealth.
- **Teladoc** services remain available **24/7 at \$0 cost share.**
- Telehealth from in-network providers applies the **same cost share** as an in-office visit (e.g., PCP or specialist rates). Members should refer to their EOC for full cost-share details.
- **No technology requirement**—audio-only telehealth is permitted for certain non-behavioral, non-mental health services.

If you have any questions, please contact your Provider Engagement Representative.

<https://mailchi.mp/4edbd40eed6f/pooscgsvfh-51673?e=6d63e1c4a4>

‘Vertical integration is destroying people’s ability to access care’: Payer CEOs face bipartisan congressional grilling. Jakob Emerson & Elizabeth Casolo. Beckers Payer Issues. January 22, 2026

“Vertical integration is destroying people's ability to access care': Payer CEOs face bipartisan congressional grilling”

https://www.beckerspayer.com/payer/vertical-integration-is-destroying-peoples-ability-to-access-care-payer-ceos-face-bipartisan-congressional-grilling/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J