

MISSISSIPPI MEDICAID

Claims Paid in Error By Magnolia To Be Reprocessed. LateBreaking News-Mississippi Division of Medicaid.

February 6 2026

“The Mississippi Division of Medicaid has identified claims paid by Magnolia for members that were not enrolled with Magnolia on the date of service of the claim. These claims should have been processed and paid to the provider as a fee-for-service (FFS) claim. The claims will be reprocessed and will appear on your Remittance Advice dated 2/9/2026. Two different ICNs will appear on the remittance; one FFS claim that will deny for Error “512 – Timely Filing” and the same claim **reprocessed** with an ICN that begins with “80.” The reprocessed claim will bypass the timely filing editing and process through FFS policy and pricing. For the claims that paid, the CCO will initiate an adjustment or void of the claim that was paid. This will result in a paid “FFS” claim to you and a recoupment from the CCO.

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or use the Provider Field Representative list on Medicaid’s website to identify your designated representative. The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located at 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/>

CMS, NOVITAS, RAILROAD MEDICARE

Advanced Beneficiary Notice of Non-Coverage (ABN, Form CMS-R-131). CMS. December 18, 2025

RHW: The current ABN form has expired but CMS states to continue using this expired form until further notice.

“These notices are subject to the Paperwork Reduction Act (PRA) process and are currently going through the PRA process. These notices may expire prior to the Office of Management and Budget (OMB) approval. In the event the notice expires, providers and plans may continue using the current version of the notice after the expiration date. Once the OMB control number for this notice is reauthorized, CMS will notify the industry and update CMS.gov accordingly. Providers and plans will have 60 calendar days from the date of the CMS notification to begin using the updated notice.”

Notice	Medicare Program	Type of Notice	Provider Type	Purpose	Link to Notice
Advance Beneficiary Notice of Non-coverage (ABN, Form CMS-R-131)	FFS	Financial Liability Notice	Healthcare providers (including independent laboratories, HHAs, and hospices), physicians, practitioners, and suppliers paid under Medicare Part B	Issued in order to transfer financial liability to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case.	ABN, (ZIP)Form CMS-R-131 (ZIP) ABN Form Instructions (PDF)

<https://www.cms.gov/medicare/forms-notice/beneficiary-notice-initiative>

Collaborative General Documentation Requirements Webinar: Mar. 18, 2026. Palmetto GBA. February 10, 2026

“Date 03/18/2026 01:00pm EDT - 02:00pm EDT

This is your opportunity to hear directly from the Medicare contractors regarding Medicare's General Documentation Requirements.

Representatives from all four Durable Medical Equipment Medicare Administrative Contractor (DME MAC) jurisdictions will join the Parts A and B education staff to explain what is required in the medical records, orders and related documentation to support the coverage.

Plenty of time will be allowed for questions during this webinar so we hope you will join the MACs on March 18, 2026, for this valuable education opportunity.”

Registration Link: <https://attendee.gotowebinar.com/register/1081284376860164190> Jurisdiction JH
<https://palmettogba.com/jja/did/evwbwd68mkdbus0318?cat=jja-events-and-education>

Global Surgery: Accurately Report Postoperative Visits. CMS. February 12, 2026

RHW: While this notice does not allow in this state, it is worth noting that CMS is evaluating post-operative care.

In a [report](#), the Office of Inspector General found that although practitioners aren't required to provide Medicare patients the number of postoperative visits that CMS considered in valuing the global surgery fee, overall, fewer visits are provided than are considered in the valuation.

Practitioners must report post-operative evaluation and management visits if they practice in a group of 10 or more practitioners in 1 of these 9 states: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island. You're exempt from required reporting if your practice has less than 10 practitioners, but we encourage you to report if possible.

See the [Global Surgery \(PDF\)](#) booklet for information on how to report postoperative visits in inpatient and outpatient settings.

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-february-12-2026#_Toc221627697

Optometry Services at Nursing Facilities: Bill Correctly. CMS MLN Matters. February 12, 2026

In a [report](#), the Office of Inspector General found that Medicare improperly paid optometrists for high-level evaluation and management (E/M) services at nursing facilities. These E/M services aren't usually billed by optometrists and don't meet Medicare requirements.

Optometrists visit nursing facilities to provide services like:

Eye exams for residents with diabetes and those at high risk for glaucoma

Diagnostic tests and treatment for residents with age-related macular degeneration

During the audit, OIG determined that claims didn't meet the E/M service criteria for moderate to high complexity level subsequent nursing facility care.

Learn how to bill correctly for optometry services at nursing facilities:

- [Medicare Vision Services \(PDF\)](#) booklet
- [Items & Services Not Covered Under Medicare](#) booklet
- [Medicare Preventive Services](#) educational tool

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-february-12-2026#_Toc221627697

Telehealth FAQ: Updated Feb. 4, 2026. CMS. February 12, 2026

“On February 4, 2026, CMS updated its [Telehealth FAQ](#) (PDF) document. Please review and visit the [CMS Telehealth page](#) for more information.”

Summary of Changes:

1. Through December 31, 2027, beneficiaries can receive Medicare telehealth services anywhere in the United States and territories. Starting January 1, 2028, except for behavioral health services, beneficiaries will generally need to be in a medical facility and in a rural area to receive Medicare telehealth services.
2. Through December 31, 2027, an extended range of practitioners may bill for Medicare telehealth services.
3. Under current law, beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027.
4. Physicians and/or practitioners should use POS 02 for Telehealth Provided Other than in Patient's Home or POS 10 for Telehealth Provided in Patient's Home (which is a location other than a hospital or other facility where the patient receives care in a private residence).

<https://www.cms.gov/medicare/coverage/telehealth>

Telehealth FAQ:

[https://dominoapps.palmettogba.com/palmetto/providers.nsf/files/2.4.26_telehealth_faq.pdf/\\$file/2.4.26_telehealth_faq.pdf](https://dominoapps.palmettogba.com/palmetto/providers.nsf/files/2.4.26_telehealth_faq.pdf/$file/2.4.26_telehealth_faq.pdf)

Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud. CMS MedLearn Matters. February 26, 2026

“On February 25, at the White House, Vice President J.D. Vance, HHS Secretary Robert F. Kennedy, Jr., and CMS Administrator Dr. Mehmet Oz announced new steps to crack down on fraud in Medicare and Medicaid to protect patients and taxpayers and improve affordability. The actions include deferring \$259.5M of quarterly federal Medicaid funding in Minnesota to prevent payment of questionable claims while further investigation is completed; a nationwide moratorium on Medicare enrollment for certain DMEPOS suppliers; and a nationwide call to action for Americans to support fraud prevention, including stakeholder input on how CMS can continue to expand and strengthen its efforts. Together, these steps reflect a coordinated, data-driven strategy to prevent fraud before it occurs, hold bad actors accountable, and protect taxpayer dollars.

More Information:

- [Full press release](#)
- [Nationwide Temporary Moratoria on Enrollment of DMEPOS Supplier Medical Supply Companies](#) notice
- [Request for Information: Comprehensive Regulations to Uncover Suspicious Healthcare](#) proposed rule: Submit comments by March 20
- [Crushing Fraud, Waste, & Abuse](#) webpage”

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-february-26-2026#_Toc222983695

DME: Complying with Proof of Delivery Requirements. CMS MedLearn Matters. February 26, 2026

RHW: The Proof of Delivery also applies to the delivery of post-cataract surgery eyeglasses.

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 [Complying with 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-february-26-2026#_Toc222983695

OTHER

March Vision New Reimbursement Platform. March Vision-UHC (Spectera) Vision. January 2026

“As part of our ongoing commitment to simplify and improve payment transactions for your business, we are excited to partner with Optum Financial and ECHO Health, Inc. to provide you with new electronic methods for quicker reimbursement and more efficient payment reconciliation.

Beginning in January 2026, March Vision Care will partner with Optum Financial and ECHO Health, Inc. to provide these new electronic methods. After this transition, you will no longer use the current payment platform: PaySpan/Zelis. Many of our providers already work with Optum Financial today, making this change a familiar one.

“Outlined below are the payment options and any action items needed by your office:

1. **Virtual Card Services**: NO ACTION IS NECESSARY to start receiving Virtual Credit Card payments.

If you are not currently registered to receive payments electronically, beginning in January 2026, you will receive Virtual Credit Card payments with your Explanation of Payment (EOP). If you have a HIPAA certified fax number on file, your office will receive fax notifications; if not, your virtual card will be mailed. Each notification will contain a virtual credit card with a number unique to that payment transaction including an instruction page for processing. The steps for processing this payment is like how you manually key-in patient payments today. Be sure to enter the payment information for the full amount of the card's value and do so prior to the expiration date on the card. Normal transaction fees apply based on your merchant acquirer relationship.

To manage your Virtual Card payment, please visit <https://echovcards.com/letter>. To access this site, you will need your Tax ID and verification access

2. **New to EFT Payments**: If you are interested in receiving payment via electronic funds transfer (EFT), setting up EFT is a fast and reliable method. In addition to your banking account information, you will need to provide a Optum Financial payment draft number and payment amount as part of the enrollment authentication. Optum Financial is committed to data privacy and security, and the prevention of fraud. They employ the latest intrusion prevention and fraud mitigation technologies to protect their clients. Their fraud mitigation strategy includes specific authentication, identity and account verification vendor technologies, and robust internal fraud prevention protocols to identify potential fraud before processing payments to enrolled accounts.

Please note: Payment will appear on your bank statement from Huntington National Bank and ECHO as “HNB – ECHO.”

To sign-up to receive EFT from all payers processing payments on the ECHO platform, visit <https://enrollments.echohealthinc.com/EFTERAInvitation.aspx>. A fee for this service may be required.

3. **Medical Payment Exchange (MPX)**: MPX is an electronic payment delivery method that offers a variety of payment options including the ability to convert provider checks into a real-time Virtual Card, enroll in ACH for all future payments, or print the check directly to a local printer.

If you are not enrolled to receive payments via electronic funds transfer (EFT) and opt-out of virtual card payments, you may receive a fax or emailed offer to enroll for MPX when you have a payment available.

Note: If you have enrolled for MPX with another payer, you must opt out of virtual cards with March Vision Care to receive your payments in your MPX portal account from us.

4. **Paper Check**: To receive paper checks and paper explanation of payments (EOP), please visit <https://echovcards.com/letter> to indicate your preferred payment method. *(To access this site, use your Tax ID and verification access code provided in the virtual card section above).*

835 Electronic Remittance Advice (ERA):

Providers who enroll for EFT payments will continue to receive the associated ERAs from ECHO with the Optum Financial Payer ID. If you have not already, please make sure that your Practice Management System is updated to accept the Optum Financial Payer ID. All generated ERAs will be accessible to download from the ECHO provider portal. (www.providerpayments.com).

Changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Enrollment team at 440.835.3511.

In addition, we want to remind you that you will still be able to access a detailed explanation of payment for each transaction like you have in the past, by logging into www.providerpayments.com. It's an easy way to keep your payment records organized and cut down on administrative tasks.

We encourage all providers to download any necessary payment statements from PaySpan/Zelis before the cutoff date of January 31, 2026. After this date, access to historical payment data through PaySpan/Zelis will no longer be available.

If you have any difficulty with the website or have additional questions, please call Optum Financial at (888) 686-3260. We appreciate your support as we roll out these new payment options and look forward to continuing to work with you to deliver a positive experience for your patients.

As for option number 2, it seems the fee is related to providers choosing the premium option for their account. Unfortunately, more information on what the benefits of the premium option are have not been yet sent.”

Reminder: Check Three Items to Verify Ambetter from Magnolia Health Member Eligibility. Magnolia Health. February 20, 2026

Grace Periods for Members receiving an APTC: Members enrolled in a Marketplace health plan are responsible for completing their premium payments each month. Members that do not make their premium payments in a timely manner enter a Grace Period, which begins with the first month a payment is missed.

Check:

1. Eligibility
 - a. **Active:** The member is in good standing and has paid premiums in full.
 - b. **Active – Pending Investigation** (Availity Only): The member is behind in paying the premium.
 - c. **Delinquent** (non-Availity Secure Portals Only): The member is behind in paying the premium and the Claims Paid Through Date is in the future.
 - d. **Suspended** (non-Availity Secure Portals Only): The member is behind in paying the premium and the Claims Paid Through Date is in the past.
 - e. **Inactive:** The member is ineligible, and coverage has been terminated.
2. Premium Paid Through Date - latest date through which premiums have been paid
3. Claims Paid Through Date - last date for which a claim for rendered services has been paid or will be considered for payment

<https://www.ambetterhealth.com/en/ms/provider-resources/provider-news/reminder-check-three-items-to-verify-member-eligibility/>

CMS Plans Beta Launch of Federal Provider Directory. Paige Twenter. Becker’s Payer Issues. February 23, 2026

“CMS outlined next steps for its Medicare Advantage provider directory and shared plans to “beta launch” a broader National Provider Directory later this year, according to a Feb. 18 document.

The agency has structured the initiative in three phases. The first phase, launched in fall 2025, displayed Medicare Advantage provider data during open enrollment in an interim tool. Lawmakers [raised concerns](#) about conflicting and duplicative information in that data, which was collected by a third-party vendor.

Phase two establishes a system for MA organizations to directly [provide](#) CMS with current information on in-network providers and facilities, according to the document. For this directory, testing will be underway between May and August, with plans to release it Oct. 1.

From there, the third and final phase will focus on testing and launching a National Provider Directory.”

https://www.beckerspayer.com/payer/cms-plans-beta-launch-of-medicare-advantage-provider-directory/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J

Eyemed Is the Exclusive Provider for Routine Vision Benefits for Aetna® Medicare Advantage (MA) Individual Plan Members. Aetna Office Link Updates. March 2026, p 23.

Effective January 1, 2026, Aetna MA Individual plan members must see an EyeMed provider for their routine vision benefits (exams and prescription eyewear) for those benefits to be considered in-network. Always check eligibility Some members have plans that provide only in-network benefits, while others have plans that provide both in- and out-of-network vision and eyewear coverage. Remember to verify benefits and eligibility via Availity® or your preferred vendor or clearinghouse.*

HMOs and PPOs Aetna MA Individual plan members (HMO/PPO) have access to the Aetna MA contracted network for Medicare-covered (medical/diagnostic) eye care services. Providers not contracted with EyeMed will only be reimbursed up to \$50 for any routine (non-Medicare covered) eye exam services rendered for PPO members. Consult the chart below for 2026 routine eye exam and eyewear benefits (non-Medicare covered).

Plan type	EyeMed provider	Non-EyeMed provider
HMO plan members	<p>\$0 copay for one non-Medicare covered routine eye exam.**</p> <p>\$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.</p>	Not covered
PPO plan members	<p>\$0 copay for one non-Medicare covered routine eye exam.**</p> <p>\$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.</p>	<p>\$0 copay for one non-Medicare covered routine eye exam up to \$50.** Members are responsible for any billed amount over \$50.</p> <p>\$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.</p>

<https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-march-2026-olu.pdf#state-specific>

Aetna Office Link: <https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-march-2026-olu.pdf#important-policy-updates>

Aetna: Complete Your Required Medicare Compliance Training and Attest By October 31, 2026. Aetna Office Link Updates. March 2026, p 22.

“All participating providers in our Medicare Advantage (MA) plans must meet Centers for Medicare & Medicaid Services (CMS) compliance program requirements for First-Tier, Downstream, and Related Entities (FDRs). This includes completing the required trainings and submitting your annual attestation for MA plans, which include HMO, PPO and Special Needs Plans (SNPs). In 2026, we’ll send training and attestation notices to the compliance email(s) you provided on your 2025 attestation. If we don’t have your compliance email address or if the email bounces, you’ll receive a postcard reminder to complete your annual attestation (and Model of Care training, if applicable).

Our training materials

Training materials and attestations are posted on our [Medicare Resources and Support](#) page.

Trainings

- [FDR Medicare compliance guide \(PDF\)](#)
- [SNPs Model of Care \(MOC\) provider training \(PDF\)](#)
- [Provider and delegate frequently asked questions document \(PDF\)](#)

Attestations based on contracted plans Providers:

- [MA/MMP: Complete MA and/or MMP attestation \(PDF\)](#)
- [MA/SNP: Complete MA and SNP attestation \(PDF\)](#)

Delegates:

- MA/MMP: [Complete MA/MMP attestation for first-tier entities \(PDF\)](#)
- MA/SNP: [Complete MA and/or SNP attestation for first-tier entities \(PDF\)](#)

Where to get more information

If you have questions, please choose from the above links or review the [quarterly First-Tier, Downstream, and Related Entities \(FDR\) compliance newsletters](#).

<https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-march-2026-olu.pdf#state-specific>

Aetna Office Link: <https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-march-2026-olu.pdf#important-policy-updates>

March Vision: Electronic payment update: Optum Financial Services. February 26, 2026

“UnitedHealthcare | March Vision Care has partnered with Optum Financial and ECHO Health, Inc. to replace our payment platform, PaySpan/Zelis, beginning Jan. 9, 2026. Access detailed payment explanations for each transaction at providerpayments.com. For questions or technical support, contact Optum Financial at 888-686-3260.

Note, when completing enrollment, be sure to select “March Vision” as the payer. Choosing “UHC” or “United Health Care” may cause the payer to appear as unrecognized.”

<https://view.provideremail.uhc.com/?vawpToken=3W2FIKLPWPXUBODP2Y3NPQWBNA.60261>

March Vision: February is Low Vision Awareness Month

“Early referrals to low vision specialists and vision rehabilitation programs can help patients maintain independence.”

<https://www.uhcprovider.com/vision/marchvision-news-feb-low-vision-awareness.html?cid=em-providernews-PCA12600123-feb26>

If Trader Joe's Ran Your Hospital— 3 ½ Things Healthcare [or EyeCare Office] Could Do Differently. Mary Meyer, MD, MPH. MedPage Today. February 3, 2026

RHW: For your reading pleasure, a little comic relief!

“As I maneuvered my way out of the [Trader Joe’s] parking lot, a cheeky thought occurred to me: *why can't my hospital be more like Trader Joe's?* In fact, as a frontline emergency medicine physician, I can think of 3 ½ industry-disrupting ideas that American healthcare might want to steal from this quirky and thriving grocery store chain.”

https://www.medpagetoday.com/opinion/calamities/119710?xid=nl_secondopinion_2026-02-03&mh=d530d60d447e978281954fa4d597664f&zdee=gAAAAABm4wxixXOEzKiBSsb6aj8cJdpE5vzvovRUbe7ess78fc8PayW-dEI3Gmd2osS83XEjhAF171BN78ot0dDa5Z_klvMZ6rbftQIF164--yFYdhGUWGs%3D&utm_source=Sailthru&utm_medium=email&utm_campaign=SecondOpinions_020326