February 2025 Third Party Changes of Significance

Corporate Transparency Act Reporting Requirements Back In Effect . AOA First Look. February 20, 2025

RHW: Urgent MUST READ

"On Feb. 18, the U.S. District Court for the Eastern District of Texas ruled in favor of the U.S. Department of the Treasury, effectively putting beneficial ownership information (BOI) reporting requirements under the Corporate Transparency Act (CTA) back into effect. For the vast majority of small businesses, including independent optometry practices, the new deadline to file a BOI report is March 21, 2025.

Congress enacted the CTA, which originally took effect in 2024, to make it easier for the federal government to crack down on shell companies used for illegal activities. Although optometry practices are not involved in such activities, many would be required to report information about their ownership to the Financial Crimes Enforcement Network (FinCEN), a Treasury Department agency, or face penalties.

The AOA continues to advocate for relief from this administrative burden. Meanwhile, the AOA will continue to provide CTA updates and resources, including a FAQ, compliance guide and informational webinar available on AOA EyeLearn. "

Feds Not Issuing Fines or Penalties in Connection with Beneficial Ownership Information Reporting Deadlines. AOA PAC Insider. March 3, 2025

"The U.S. Department of the Treasury Financial Crimes Enforcement Network (FinCEN) announced this week that it will not issue any fines or penalties or take any other enforcement actions against any companies based on any failure to file or update beneficial ownership information (BOI) reports pursuant to the Corporate Transparency Act by the current deadlines.

"No fines or penalties will be issued, and no enforcement actions will be taken, until a forthcoming interim final rule becomes effective and the new relevant due dates in the interim final rule have passed. This announcement continues Treasury's commitment to reducing regulatory burden on businesses, as well as prioritizing under the Corporate Transparency Act reporting of BOI for those entities that pose the most significant law enforcement and national security risks," said the FinCEN release.

No later than March 21, 2025, FinCEN intends to issue an interim final rule that extends BOI reporting deadlines, recognizing the need to provide new guidance and clarity as quickly as possible, while ensuring that BOI that is highly useful to important national security, intelligence, and law enforcement activities is reported.

FinCEN also intends to solicit public comment on potential revisions to existing BOI reporting requirements. FinCEN will consider those comments as part of a notice of proposed rulemaking anticipated to be issued later this year to minimize burden on small businesses while ensuring that BOI is highly useful to important national security, intelligence, and law enforcement activities, as well as determining what, if any, modifications to the deadlines referenced here should be considered."

MISSISSIPPI MEDICAID

Medicaid Provider Enrollment and Data Maintenance: Requirements and Process Overview. Mississippi Medicaid Provider Bulletin. January 31, 2025

RHW: I encourage you to read this entire Provider Bulletin for complete information

"…• Key Requirements for Billing Providers:

◊ Must enroll with Medicaid for each service location where services are rendered.

◊ Must submit claims with the NPI and appropriate service location details in accordance with the published Mississippi Division of Medicaid (DOM) guidance, including but not limited to Companion Guides, Job Aids, Paper Billing Manual, Late Breaking News articles, etc.

◊ Billing providers must also ensure that any individual practitioners included on a claim are properly enrolled and affiliated, if applicable.

◊ Billing providers are subject to comprehensive screening as they have direct financial interactions with Medicaid, which may include moderate to high-risk screenings, depending on the provider's taxonomy. …"

https://medicaid.ms.gov/wp-content/uploads/2025/01/January-2025-Provider-Bulletin.pdf

Provider Recredentialing Mississippi Medicaid Managed Care Programs. Mississippi Medicaid Provider Bulletin. January 31, 2025

"All providers participating in MississippiCAN or the Children's Health Insurance Program (CHIP) are required to be credentialed by the Mississippi Division of Medicaid. Failure to complete credentialing/recredentialing will result in termination from these programs and will require reenrollment. There are a significant number of providers currently due for recredentialing that need to complete the process. Providers terminated for failing to recredential may reenroll for Medicaid's managed care programs (MSCAN/CHIP) through the MESA Provider Portal. …"

https://medicaid.ms.gov/wp-content/uploads/2025/01/January-2025-Provider-Bulletin.pdf

Marketplace Policies and Medicaid Coverage. Mississippi Medicaid Late Breaking News. February 13, 2025

"Medicaid members are allowed to purchase Marketplace plans. These policies are considered primary, and Medicaid will be the secondary payor. Providers should bill the Marketplace policy prior to billing Medicaid. The original explanation of benefit (EOB) from the Marketplace carrier must be attached to the claim if filing paper or MESA web portal.

Members who are not aware of their Marketplace coverage should be instructed to reach out to the Marketplace carrier to disenroll/cancel the policy. After disenrollment/cancellation of the policy, the member should contact the Office of Recovery at (601) 359-6095 with the termination date and reference number provided by the Marketplace plan. Providers should rebill the claim once the updates are completed in MESA. If you have additional questions, please contact the Office of Recovery at (601) 359-6095."

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

January Provider Bulletin Now Available. Mississippi Medicaid Late Breaking News. January 31, 2025

"The January issue of the **MS Medicaid Provider Bulletin** is now available online for read or download. The Provider Bulletin aims to inform providers of Medicaid news, policy changes, and provides contact information for provider field representatives listed by county, and more.

Previous issues of the Provider Bulletin are archived online at https://medicaid.ms.gov/providers/provider-resources/provider-bulletins/."

Information about the following:

Medicaid Provider Enrollment and Data Maintenance: Requirements and Process Overview
DOM MESA Web Portal Reminder
Provider Recredentialing Mississippi Medicaid Managed Care Programs
Managed Care Inquiries and Complaints – Magnolia, Molina, United Health Care

https://medicaid.ms.gov/wp-content/uploads/2025/02/January-2025-Provider-Bulletin.pdf

CMS, NOVITAS, RAILROAD MEDICARE

Act Now – Urge Your Lawmaker to Back Medicare Pay Legislation and Include in Spending Bill. AOA PAC Insider. March 3, 2025

"With the March 14 expiration of 2024 end-of-year spending legislation, Congress now has two weeks to develop and approve legislation to keep the government open and operating.

With the upcoming deadline, the AOA is focused on ensuring that programs beneficial to ODs and patients are not on the chopping block. The AOA and other physician organizations also see the spending bill negotiations as the best opportunity to advance legislation ending ongoing Medicare pay cuts.

While last year's spending bill did include an AOA-backed provision to largely eliminate this year's Medicare pay cut, it and all other health provisions were stripped from the bill before it advanced. That meant a 2.8 percent Medicare pay cut went into effect Jan. 1, 2025 – and is still hitting ODs and others today.

That's why the AOA and other physician organizations are backing legislation that would address the cut and provide a fix for the rest of the year. The legislation, called the Medicare Patient Access and Practice Stabilization Act (H.R. 879), would stop the ongoing Medicare pay cut April 1 and provide a 6.62 percent increase from April 1 to the end of the year to help make up for the cuts sustained through the beginning of the year.

Congress won't have many larger legislative vehicles to deal with the Medicare pay issues over the next few months, making it critical that ODs weigh-in with their lawmakers now asking that they support H.R. 879 and push to include it in the upcoming spending package. Please act now.

Click here to see if your lawmaker is a co-sponsor of H.R. 879. If not, use the AOA's Online Action Center or text PAYMENT to 855.465.5124 to urge your House member to join as an official supporter of the bill and urge them and your senators to fight for its inclusion in the upcoming spending bill."

Checking Medicare Eligibility MLN Fact Sheet. Railroad Medicare - Palmetto GBA. February 6, 2025

"This CMS Medicare Learning Network fact sheet contains guidance for providers on checking patients' Medicare eligibility. "

https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf

DMEPOS. Railroad Medicare - Palmetto GBA. February 5, 2025

"The January 2025 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 shall 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."

"Access CMS-level guidance for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) through the following links.

- Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, & Supplies (DMEPOS) page
- January_2025 DMEPOS_Jurisdiction_List (PDF) identify the correct Medicare contractor jurisdiction for DMEPOS HCPCS codes
- CMS DMEPOS Competitive Bidding Program website

Other CMS Guidance

- Durable Medical Equipment (PDF) CMS Medicare Benefit Policy Manual, Chapter 15, Section 110
- DMEPOS (PDF) CMS Medicare Claims Processing Manual, Chapter 20
- DMEPOS Fee Schedules"

https://www.palmettogba.com/palmetto/rr.nsf/DID/7GYG851325#ls

Telehealth FAQ. CMS. January 8, 2025

"We make any additions or deletions to the services defined as Medicare telehealth services effective on a January 1st basis. The annual physician fee schedule proposed rule published in the summer and the final rule (published by November 1) is used as the vehicle to make these changes. The public has the opportunity to submit requests to add or delete services on an ongoing basis.

Because CMS intends to use the annual physician fee schedule as a vehicle for making changes to the list of Medicare telehealth services, requestors should be advised that any information submitted, are subject to disclosure for this purpose."

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

Telehealth FAQ: https://www.cms.gov/files/document/telehealth-faq-1-8-25.docx

Checking Medicare Eligibility MLN Fact Sheet. CMS MedLearn. February 20, 2025

"This CMS Medicare Learning Network fact sheet contains guidance for providers on checking patients' Medicare eligibility."

https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf

HHS To End Some Public Notice And Comment Rules For Policymaking. AOA First Look. March 3, 2025

"Modern Healthcare (2/28, Early, Subscription Publication) reported the Health and Human Services Department (HHS) is discontinuing 'a Nixon-era practice that offered transparency into federal policymaking in a move that limits the public and the healthcare sector's ability to influence government actions.' Secretary Kennedy announced this change in a policy statement published on Friday, stating that HHS will now adhere to the minimum requirements of the Administrative Procedures Act (APA) and 'only engage in the traditional notice-and-comment process as expressly dictated by that law." This new approach limits public engagement in agency management, grants, and contracts, allowing HHS to "skip notice and comment if it determines that process would be unnecessary, impractical or 'contrary to the public interest,' he wrote.'"

https://www.modernhealthcare.com/policy/hhs-public-comment-rfk

OTHER

E/M Experts Offer CPT Advice for Physician Private Practices. (2024 AMA CPT and RBRVS Annual Symposium). Andis Robeznieks. AMA CPT News. February 20, 2025. (Published January 14, 2025)

RHW: Responses from geriatrician Peter Hollmann, MD (geriatrician), w and Barbara Levy, MD (ob-gyn) - co-chairs of the work group that developed the E/M changes, which were later rolled out across other settings

"…**Q: If a patient in the ED is given a prescription drug to treat an acute condition, is this considered prescription-drug management?**

Yes, answered Dr. Levy—even if the drug administered is an over-the-counter medication, because there is management as well as medical decision-making.

"If you tell somebody to take a baby aspirin or use aspirin, that's still management of the patient for the acute condition," she explained. "It doesn't require long-term therapy. It doesn't require highly complex medications."

Q: If a patient has a number of conditions and medications, but none are specifically life-threatening, is it appropriate for private practice physicians to report CPT code 99215—high level evaluation and management of an established patient in an office setting? If, for example, the patient has 11 diagnoses and takes 25 medications, is balancing all of those considered "complex" even if none is potentially life threatening?

No, answered Dr. Hollmann, explaining that one element used in selecting the appropriate level of service is the number and complexity of problems addressed in the patient encounter. If 10 out of those 11 conditions are not addressed and do not contribute to the amount or complexity of data that need to be reviewed and analyzed, a higher level of E/M is not required for the encounter.

"For the problem addressed to be high-level medical decision-making, it would have to be one or more chronic illnesses with severe exacerbation and progression of side effects," Dr. Hollmann said. "This case would be 'moderate' as far as the level of the problem addressed." …"

https://www.ama-assn.org/practice-management/cpt/em-experts-offer-cpt-advice-physician-private-practices?utm_source=SFMC&utm_medium=email&utm_term=2202025&utm_content=HS_Email_Comm_CPT_News_Feb_2025&utm_campaign=CPT%20News%202025&utm_asset_name=CPT%20News%202025&utm_channel_name=

Ambetter from Magnolia Health introducing Availity Editing Services. Magnolia Health. February 13, 2025

"In a continuous effort to make it easier to do business with us, Ambetter from Magnolia Health is introducing Availity Editing Services (AES). Starting Jan. 24, 2025, Centene is partnering with Availity to return rejection messages on its behalf via AES messages. These messages will show in your existing workflows. 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 in order 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 work basket or que reporting. If you submit claims via the Availity portal, any of these rejections will show on 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. On 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 user show 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 Ambetter from Magnolia Health Provider Engagement Representative.

https://mailchi.mp/4809858108f6/pooscgsvfh-34014?e=6d63e1c4a4

New Provider Demographic Update Tool. Magnolia Health. February 13, 2025

"Magnolia Health is committed to providing our providers with the best tools possible to support their administrative needs for MSCAN and Ambetter.

Whether it's making an address change or terminating a provider, we have created an easy way for you to request updates to your information and ensure we receive what is needed to complete the request in a timely manner.

Try the Provider Demographic Tool Today! https://www.magnoliahealthplan.com/providers/resources.html

Please note, MSCAN and Ambetter Delegated Providers will continue to submit rosters to magnoliacredentialing@centene.com

Wellcare Providers will continue to submit rosters and demographic updates to msproviderupdates@centene.com

Need to review your existing information or have a question? If you are a contracted provider, you can visit our Provider Directory to review your information https://www.magnoliahealthplan.com/find-a-doctor/find-a-provider-guide.html."

https://mailchi.mp/4809858108f6/pooscgsvfh-34014?e=6d63e1c4a4

UHC Provider Portal Authentication. United Health Care. February 17, 2025

"A security update to the UnitedHealthcare Provider Portal is coming soon. This will affect how you sign in to the portal and gain access if you're ever locked out.

Currently, many of you use email as a recovery and multifactor authentication option. On March 6, 2025, this option won't be available. Be prepared; review your options now.

1. You'll need your own One Healthcare ID; if you share a One Healthcare ID, **register** for your own now
2. You'll need access to one of the following: mobile phone, direct landline phone number or desktop authentication option
3. Starting January 2025, you'll need to download and save a recovery code …"

https://www.uhcprovider.com/en/access/provider-portal-authentication.html

UHC Help Your Patients Find the Care They Need. United Health Care. February 1, 2025

"Review and verify your provider data today …

In a recent study of our provider directory, we discovered that the data we're given by organizations is often inaccurate. Specifically, we found that providers were no longer with the practice, listed with the wrong specialty, had outdated/wrong contact information or were no longer accepting new patients.

As a result, members are unable to make their desired appointments and potentially may lead to increased cost of care. … Ways to verify your data…"

https://www.uhcprovider.com/en/resource-library/news/2025/attest-data-aid-patients-q1.html?cid=em-providernews-2025nnb3-Feb25

Ensure You And All 3rd Party Vendors Have UnitedHealthcare Provider Portal Access. United Health Care. February 17, 2025

"Due to increased promotion, you might see additional UnitedHealthcare Provider Portal access requests from 3rd party vendors/revenue cycle management companies. Access and use of our digital tools, including the portal, is the quickest path to answers. Plus, having universal portal access is crucial to avoid disruptions and is the only way to chat with us**. …"**

https://www.uhcprovider.com/en/resource-library/news/2025/ensure-vendors-provider-portal-access.html?cid=em-providernews-2025nnb3-Feb25

UHC: Complete the Required MOC Training. United Health Care. February 17, 2025

"The Centers for Medicare and Medicaid Services (CMS) requires all special needs plans (SNPs) to provide initial and annual Model of Care (MOC) training to network providers who are contracted to see SNP members and out-of-network providers who routinely see SNP members.

Complete the SNP MOC training

To meet the requirement, complete our 10-minute, self-paced SMP MOC training course by Dec. 31, 2025. We encourage you to complete the training prior to engaging with SNP members. …"

https://www.uhcprovider.com/en/resource-library/news/2025/complete-required-moc-training.html?cid=em-providernews-2025nnb3-Feb25

UHC: Avoid Claim Rejections and Denials. United Health Care. February 17, 2025

"Reasons why corrected, duplicate and multiple claims are rejected

Effective April 1, 2025, we will enforce CMS and health plan guidelines by rejecting or denying the following types of claims:

- Multiple new claim submissions for the same date of service
  Submit 1 claim for all services rendered on the same date(s) of service by the same health care provider for an individual member. If you submit multiple original claims for the same date(s) of service, the original submission will adjudicate, and the system will reject the subsequent claims and request a corrected claim.
- Corrected claims with missing or incorrect information
  When making changes to a claim, the corrected claim replaces the original. The original claim is no longer valid. To avoid corrected claims from being rejected, apply the following tips:
  - Allow the original claim to be adjudicated prior to submitting a correction
  - Include all originally billed services rendered to the member by the individual health care provider, not just the line you're correcting. Failure to submit all previous billed services on a corrected claim will result in an overpayment recovery of the excluded services.

    - Code the claim with the frequency code "7" and the original claim number
- Duplicate claims with identical service codes and dates of services
    - If you haven't received payment within the standard processing time, check the claim status before resubmitting a new one. Resubmitting a claim while the original claim is being adjudicated may create a duplicate claim, which the system will reject. This may further delay processing and payment.
    - If your claim has already been adjudicated, you can submit changes to your billing on a corrected claim
    - If you disagree with the processing outcome, you can request a claim reconsideration. View our Online Reconsiderations and Appeals/Disputesopen_in_new interactive guide to learn more. …"

https://www.uhcprovider.com/en/resource-library/news/2025/avoid-claim-rejections-denials.html?cid=em-providernews-2025nnb3-Feb25

United HealthCare – Commercial and Individual Exchange Plans- Neurophysiologic Testing and Monitoring Policy Number: 2025T0493GG. Effective 02/01/2025.

Oxford Policy DIAGNOSTIC 047.30 Effective Date: February 1, 2025

RHW: Note that in previous versions and this version that the following has been listed as not medically necessary: 0464T Visual evoked potential testing for diagnosing and evaluating glaucoma

No changes applicable to Optometry

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/neurophysiologic-testing.pdf

Oxford policy: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/oxford/neurophysiologic-testing-monitoring-ohp.pdf

UnitedHealthcare -Commercial Medical Benefit Drug Policy Tepezza® (Teprotumumab-Trbw) Policy Number: 2025D0089K And UHC Community Plan Policy CS2025D0089N. Effective Date: March 1, 2025.

Revised coverage criteria: Added criterion requiring:

Presence of moderately to severe disease, associated with presence of stable, chronic (inactive) disease and one of the following:

Greater than or equal to 3 mm in proptosis from before diagnosis of TED; or

Proptosis ≥ 3 mm above normal values for race and sex (i.e., 19 and 21 mm for white female and male patients, respectively; and 23 and 24 mm or black female and male patients, respectively)

Replaced criterion requiring:

- "Diagnosis of Graves' disease associated with active thyroid eye disease (TED) with a Clinical Activity Score (CAS) ≥ 4 in the most severely affected eye" with "diagnosis of thyroid eye disease (TED)"
- "Presence of moderately to severely active TED, associated with at least one of the following:
    - lid retraction ≥ 2 mm, moderate or severe soft tissue involvement,
    - exophthalmos ≥ 3 mm above normal for race and gender, or
    - diplopia" with "presence of moderately to severe disease, associated with the presence of symptomatic, active disease and one of the following:
        - lid retraction ≥ 2 mm,
        - moderate or severe soft tissue involvement,
        - proptosis ≥ 3 mm above normal for race and sex, or diplopia"
- "History of intolerance, failure, or contraindication to oral or intravenous glucocorticoids (e.g., prednisone, methylprednisolone)" with "presence of either significant proptosis or diplopia or both of the following: absence of either significant proptosis or diplopia, and history of intolerance, failure, or contraindication to oral or intravenous glucocorticoids (e.g., prednisone, methylprednisolone)"

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/tepezza-03012025.pdf

Community Plan: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/comm-plan/tepezza-cs-03012025.pdf

UnitedHealthcare Medicare Advantage Medical Policy Brow Ptosis and Eyelid Repair Policy Number: MMP007.08 Effective Date: February 1, 2025

"Updated list of documents available in the Medicare Coverage Database to reflect the most current information"

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-mp/brow-ptosis-eyelid-repair.pdf

Prepare For GEHA Member Transition To UMR. United Health Care. January 16, 2025

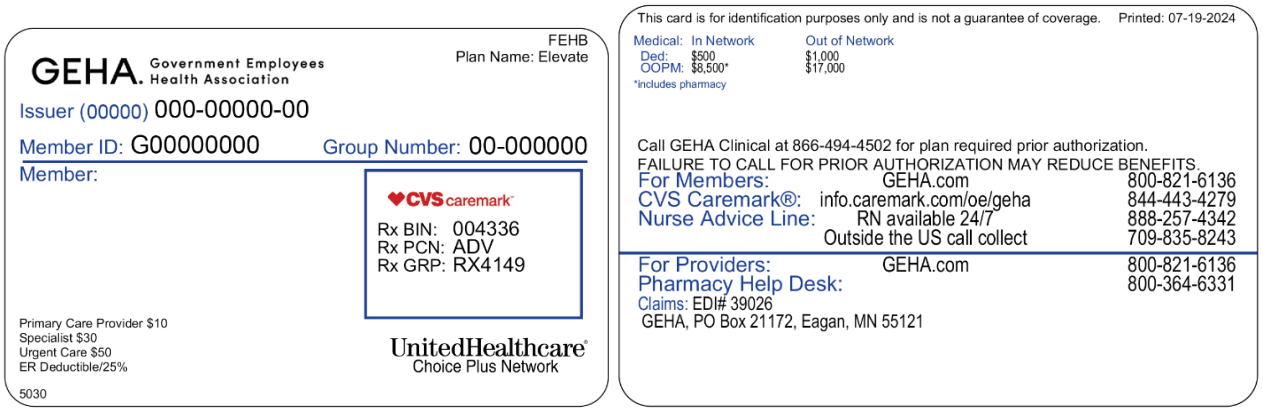
On Jan. 1, 2025, GEHA transitioned from UnitedHealthcare Shared Services to full-service UMR operations. While this means that UMR will provide administrative support for the GEHA plans, the portal and all associated services will continue to be GEHA-branded. UMR will continue to provide the UnitedHealthcare-contracted Choice Plus or Select Plus networks to support GEHA and its members with a simplified and streamlined approach to their GEHA benefits.

What this means for you

You will continue to log in to the GEHA portal and use your One Healthcare ID to access tools and resources. As of Jan. 1, 2025, you will use the payer ID 39026 for all electronic claim submissions. If you need to mail paper claims, please use this new address:

Claims: EDI# 39026
GEHA, P.O. Box 21172
Eagan, MN 55121

GEHA members have received new medical ID cards. Please note that all members have new member ID numbers and group numbers, and there are some changes to the claim submission process, so using information on the member's new ID card is critical to ensure timely and accurate claim payment. The following ID card is an example of what it looks like:



Sample member ID card for illustration only; actual information varies depending on payer, plan and other requirements.

Questions? Refer to our FAQopen_in_new or contact your GEHA representative.

https://www.uhcprovider.com/en/resource-library/news/2025/geha-transition-umr.html?cid=em-providernews-2025nnb3-Jan25

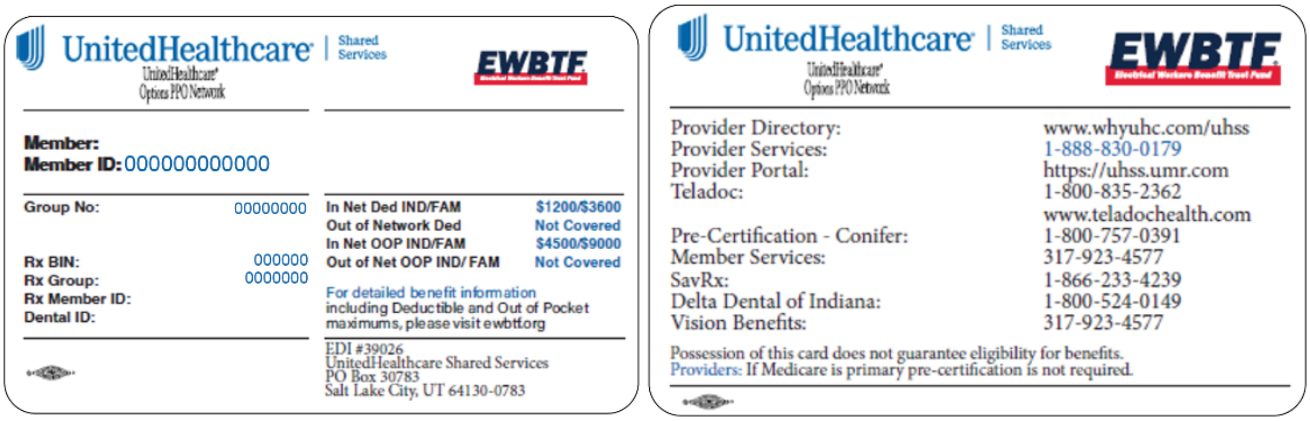
Prepare For New Options PPO Network Members. United Health Care. January 16, 2025

"Beginning Jan. 1, 2025, the Electrical Workers Benefit Trust Fund Local 481 members will have access to the Options PPO network.

What this means for you

To view benefits, eligibility, prior authorization requirements and claim updates for these new members, please visit the UnitedHealthcare Shared Services (UHSS) Portal

You don’t need to take any action during this transition. You can recognize Electrical Workers Benefit Trust Fund Local 481 members by looking at the following member ID card:



Sample member ID card for illustration only; actual information varies depending on payer, plan and other requirements.

Electrical Workers Benefit Trust Fund Local 481 members will have access to the national UnitedHealthcare Options PPO network of health care professionals and facilities. Please refer to the member’s ID card for contact information on medical utilization management services including notification, initial determination and inpatient care management.

Questions? We're here to help.

Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal.open_in_new For additional contact information, visit our Contact us page.

https://www.uhcprovider.com/en/resource-library/news/2025/electrical-workers-benefit-options-ppo.html?cid=em-providernews-2025nnb3-Jan25

VSP Policy Change. VSP Provider Hub. November 26, 2024

“Effective Jan. 1, 2025, VSP will increase the allowed amounts for daily replacement lenses under the Covered Contacts and Visually Necessary Contact Lens maximums by 15% to 20%. These changes will apply to claims with dates of service starting Jan. 1, 2025, and going forward. Please review your provider manual for more details. “

https://www.vspproviderhub.com/news/operational-updates/covered-contact-lenses-visually-necessary-contact-lenses-increased-maximum-allowed-for-daily-replacement-lenses#:~:text=Good%20news!%20Effective%20January%201%2C%202025%2C%20VSP%C2%AE,starting%20January%201%2C%202025%2C%20and%20going%20forward