

MISSISSIPPI MEDICAID

**Claims Paid in Error by Magnolia Health to Be Reprocessed. Magnolia Weekly News Blast. March 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/wp-content/uploads/2025/09/Q3-2025-PROVIDER-FIELD-REPRESENTATIVES_Map-and-By-County_v1.0.pdf).”

Provider Standards for Appointment Scheduling

We want to ensure appointments for medical services and behavioral health services are available to our members on a timely basis. Below are the Appointment Availability standards, which can also be found in the provider manuals. Please ensure these standards are implemented accordingly by your practice.

After Hours - All Providers (All Products)	MSCAN and MSCHIP Health Plans (Medicaid)
 <p>After Hours (Passing Standards):</p> <ul style="list-style-type: none"> <li>• <b>24/7 Coverage:</b> Primary Care Providers (PCPs) must ensure that they, or another qualified medical professional, are available or accessible to members 24 hours a day, 7 days a week.</li> <li>• <b>Prompt Response:</b> Calls to the after-hours number must be returned by a practitioner within a specific timeframe, typically <b>30 minutes</b>.</li> <li>• <b>Live Contact Option:</b> Voicemail systems alone are not acceptable. There must be a means to reach a live person or an on-call physician/medical professional.</li> <li>• <b>Emergency Instructions:</b> The after-hours message or answering service must clearly instruct patients with life-threatening conditions to dial 911 or go to the nearest emergency room.</li> <li>• <b>Language Accessibility:</b> Recorded messages or answering services should be available in languages appropriate to the practice's patient population (e.g., English and Spanish)</li> </ul>	<p><b>PCPs</b></p> <ul style="list-style-type: none"> <li>• Urgent Visit: 24 hours</li> <li>• Sick Visit: 7 days</li> <li>• Routine Visit: 30 days</li> </ul> <p><b>BEHAVIORAL HEALTH</b></p> <ul style="list-style-type: none"> <li>• Urgent Visit: 24 hours</li> <li>• Routine Visit: 14 days</li> <li>• Post Discharge: 7 days</li> </ul> <p><b>SPECIALIST PROVIDERS</b></p> <ul style="list-style-type: none"> <li>• Routine Services: 45 days</li> </ul>

Wellcare (Medicare)	Ambetter (Marketplace)
<p><b>PRIMARY CARE</b></p> <ul style="list-style-type: none"> <li>• Emergency: Same day or within 24 hours of member's call</li> <li>• Urgent Care: 24 hours</li> <li>• Sick Care: 7 days</li> <li>• Routine: 30 days</li> </ul> <p><b>SPECIALTY REFERRAL</b></p> <ul style="list-style-type: none"> <li>• Emergency: Within 24 hours of member's call</li> <li>• Urgent Care: Within 24 hours</li> <li>• Routine: 30 days</li> </ul> <p><b>BEHAVIORAL HEALTH</b></p> <ul style="list-style-type: none"> <li>• Non-Life-Threatening Psychiatric Emergency: 6 hours</li> <li>• Urgent: 48 hours</li> <li>• Routine (Initial Assessment): 10 days</li> <li>• Routine Follow Up Care: Within 30 days of assessment</li> <li>• Sick Care: 7 days</li> </ul>	<p><b>PRIMARY CARE &amp; PEDIATRIC</b></p> <ul style="list-style-type: none"> <li>• Routine Visit: 15 days</li> <li>• Non-Urgent/Sick Visit: 48 hours</li> <li>• Urgent Care: 24 hours</li> </ul> <p><b>BEHAVIORAL HEALTH</b></p> <ul style="list-style-type: none"> <li>• Non-Life-Threatening Emergency: Within 6 hours</li> <li>• Routine Visit: 10 days</li> <li>• Urgent Care: 48 hours</li> </ul> <p><b>SPECIALIST PROVIDERS</b></p> <ul style="list-style-type: none"> <li>• Routine Services: 30 days</li> </ul> <p><b>Urgent Care: 24 hours</b></p>

<https://mailchi.mp/333630ff3013/pooscgsvfh-54653?e=6d63e1c4a4>

## CMS, NOVITAS, RAILROAD MEDICARE

**Advance Beneficiary Notice of Noncoverage: Updated Form.** CMS MLN Connections Newsletter. March 19, 2026

**There is an article from June 2025 discussing the use of the Advanced Beneficiary Notice of NonCoverage (ABN) posted to the MOA Article Archive.**

“The Office of Management and Budget approved the updated [Advance Beneficiary Notice of Noncoverage](#) (Form CMS-R-131). It’s available in English and Spanish. CMS improved the readability and design. You may use the updated form now, but you **must use it starting May 12, 2026**, when the previous version expires.”

[https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-19-2026#\\_Toc224733325](https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-19-2026#_Toc224733325)

**DMEPOS: Temporary Enrollment Moratorium on Medical Supply Companies.** CMS MLN Connects Newsletter. March 5, 2026

**RHW: This does not apply to Optometrists!**

“On February 27, CMS implemented a temporary nationwide enrollment moratorium on DMEPOS medical supply companies. The moratorium will remain in effect for 6 months and may be extended in 6-month increments.

We’ll deny any initial enrollment or change in majority ownership applications submitted that violate requirements until the moratorium ends.

More Information:

- [Provider Enrollment Moratoria](#) webpage
- [FAQs \(PDF\)](#)
- [Nationwide Temporary Moratoria on Enrollment of DMEPOS Supplier Medical Supply Companies](#) notice”

[https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-5-2026#\\_Toc223438581](https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-5-2026#_Toc223438581)

**No-Pay Medicare Summary Notice Mailing Frequency Changed to Every 180 Days.** CMS MLN Connects Newsletter. March 5, 2026

“The frequency of No-Pay Medicare Summary Notices (MSNs) changed from every 120 days to every 180 days, effective January 1, 2026. Remind your patients that they can [go digital](#) to get their MSNs electronically.

More Information:

- [Medicare Claims Processing Manual, Chapter 21 \(PDF\)](#), sections 10 and 10.1
- [Instruction to your Medicare Administrative Contractor \(PDF\)](#)”

[https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-5-2026#\\_Toc223438581](https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-5-2026#_Toc223438581)

**The new NCCI edits for April 2026 have been released. The edit that was prohibiting the use of 92137 (OCT with angiography) with 92002, 92004, 92012 and 92014 has been corrected. If you had any claims for 92137 with one of the 92000 codes listed above denied, you should file a corrected claim with a -25 modifier added to the 92000 code. However, going forward, the use of the -25 modifier should no longer be required. The April 2026 NCCI procedure-to-procedure edits for 92137 include the following. Please note that 92137 is never allowed with 92133 or 92134. Providers should review all of the NCCI edits for commonly used codes.**

Column 1	Column 2	Effective Date	Modifier	PTP Edit Rationale
			0=not allowed	
			1=allowed	
			9=not applicable	
92137	76514	20251001	1	Misuse of Column Two code with Column One code
92137	92025	20251001	1	Misuse of Column Two code with Column One code
92137	92132	20251001	1	CPT Manual or CMS manual coding instruction
92137	92133	20251001	0	CPT Manual or CMS manual coding instruction
92137	92134	20250701	0	CPT Manual or CMS manual coding instruction
92137	92227	20260401	0	Mutually exclusive procedures
92137	92228	20260401	0	Mutually exclusive procedures
92137	92229	20260401	0	Mutually exclusive procedures
92137	92230	20250701	1	Misuse of Column Two code with Column One code
92137	92250	20250701	1	Misuse of Column Two code with Column One code
92137	99211	20250701	1	Misuse of Column Two code with Column One code
92137	G0117	20250701	1	Misuse of Column Two code with Column One code
92137	G0118	20250701	1	Misuse of Column Two code with Column One code
92002	92137		9	
92012	92137		9	
92004	92137		9	
92014	92137		9	

**National Correct Coding Initiative: April Update. CMS MLN Connects Newsletter. March 5, 2026**

“Get the National Correct Coding Initiative (NCCI) first quarter edit files effective April 1, 2026, on these [Medicare NCCI](#) webpages:

- [Procedure-to-Procedure Edits](#)
- [Medically Unlikely Edits](#)
- [Add-on Code Edits](#)

See the [instruction to your Medicare Administrative Contractor \(PDF\)](#). “

[https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-5-2026#\\_Toc223438581](https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-5-2026#_Toc223438581)

**HCPCS Application Summaries & Coding Determinations: Non-Drug and Non-Biological Items & Services.**

CMS MedLearn Connects Newsletter. March 12, 2026

**RHW: HCPCS codes important to Optometry have been extracted and put into a separate Excel spreadsheet. No new codes for this publication.**

“CMS published the second biannual 2025 HCPCS Level II coding, Medicare benefit category, and Medicare payment determinations for non-drug and non-biological items and services. Visit the [HCPCS Level II Coding Decisions](#) webpage for more information.”

[https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-12-2026#\\_Toc224192921](https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-march-12-2026#_Toc224192921)

### **Who's Who in Medicare: May 5, 2026. Railroad Medicare-Palmetto GBA. March 11, 2026**

05/05/2026 01:00pm EDT - 02:00pm EDT

“This presentation was developed to assist providers with a better understanding of the 12 different Medicare Administrative Contractor (MAC) jurisdictions and their respective duties assigned by the Centers for Medicare and Medicaid Services (CMS). Please plan to attend this free session.”

<https://palmettogba.com/jja/did/evxc3kmuyvc0nc80505?cat=jja-events-and-education>

### **CMS Finalizes Rule To Phase Out Fax Machines, Paper Mailings For Healthcare Claims Documentation. AOA First Look. March 23, 2026**

[Fierce Healthcare](#) (3/20, Landi) reported that CMS on Friday “finalized a rule that aims to phase out fax machines and paper mailings for healthcare claims documentation.” The rule, “called the Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures final rule, is effective on May 26.” It would “establish national standards for the electronic exchange of clinical documentation used to support healthcare claims.” Additionally, “the rule...adopts standards for electronic signatures to ensure secure, authenticated transmission of this information, CMS said.” According to Fierce Healthcare, “HIPAA-covered entities, including health plans, healthcare clearinghouses and healthcare providers that conduct electronic transactions, must comply by May 26, 2028.”

Article: <https://www.fiercehealthcare.com/regulatory/cms-proposed-rule-aims-ax-fax-machine-phase-out-paper-mailing>

### **RRB Top Medical Review Denials Module: Q2 2025. Railroad Medicare-Palmetto GBA. March 19, 2026**

“The goal of Palmetto GBA's Railroad Retirement Board Specialty Medicare Administrative Contractor (RRB SMAC) medical review program is to ensure that payment is only made for services that meet all Medicare coverage, coding and medical necessity requirements. Please review the most common provider errors in the second quarter of 2025. To view this module, please select the [RRB Top Medical Review Denials Module Quarter 2 2025](#).”

<https://palmettogba.com/rr/did/pkrbq9q1gt?cat=rr-events-and-education#ls>

## **OTHER**

### **United Health Care and March Vision: Information Regarding Their New Echo System. March 10, 2026**

From a Senior Provider Relations Advocate: “We cannot use a PO Box for a billing address for March Vision. There should not be a charge for EFT, unless the provider is selecting to have a Premium account with Echo. There is an option for Virtual Credit Card payment – they can receive this by fax if they have a HIPAA-Certified fax number on file. If there are any additional questions, they can contact Optum Financial at (888) 686-3260.”

### **United Health Care: Complete Special Needs Plan MOC Training by Dec. 31. UHC. January 26, 2026**

“The Centers for Medicare and Medicaid Services (CMS) require all Special Needs Plans (SNPs) to provide initial and annual Model of Care (MOC) training to network providers that are contracted to see SNP members and out-of-network providers who routinely see SNP members.

To comply with CMS and to help you meet this requirement, please complete our 10-minute, self-paced SNP MOC course by Dec. 31, 2026. [Go to training](#)

#### **Important training details**

- This training doesn't apply if you see only UnitedHealthcare commercial plan members
- There is no universal MOC training because care management processes vary across insurers. This means you may be asked to complete multiple trainings as required by other Medicare insurers.

- CMS may also request an attestation of the initial and annual training

#### Resources

- [UnitedHealthcare Administrative Guide, chapter 5](#)
- [SNP model of care training FAQ](#)

#### Questions? We're here to help.

If you have questions about the training, please contact the UnitedHealthcare SNP MOC training team at [snp\\_moc\\_providertraining@uhc.com](mailto:snp_moc_providertraining@uhc.com)

### **Surest (UHC): Visual Information Processing Evaluation and Orthoptic and Vision Therapy Policy Number: Medical Policy Bulletin Surest - SRST2026T0072GG Effective Date: April 1, 2026**

#### **Coverage Rationale**

##### Removed list of proven and medically necessary indications:

- o Occlusion therapy or pharmacologic penalization therapy for treating Amblyopia
- o Orthoptic therapy or Vision Therapy for treating convergence insufficiency
- o Prism adaptation therapy for treating esotropia

##### Revised list of unproven and not medically necessary indications; removed:

- o Orthoptic therapy or Vision Therapy for treating all other indications not listed [as proven and medically necessary]
- o Virtual perception therapy for treating any type of learning disability or language disorder
- o Vision restoration therapy for treating visual field deficits following stroke or neurotrauma
- o Visual information processing evaluation to diagnose reading or other learning disabilities

##### Definitions Removed definition of:

- o Convergence Insufficiency
- o Esotropia
- o Exotropia
- o Occlusion Therapy
- o Orthoptic Therapy
- o Pharmacologic Penalization Therapy
- o Prism Adaptation Therapy
- o Strabismus
- o Vision Restoration Therapy (VRT)

**Applicable Codes Removed:** CPT codes 92065, 92066, and 92499

#### **Supporting Information**

Updated Clinical Evidence and References sections to reflect the most current information

Removed Description of Services section Archived previous policy version 2026T0072FF

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/surest/visual-info-processing-eval-orthoptic-vision-therapy-sur-04012026.pdf>

### **Understanding and Responding to Licensing Boards. Amy Fitzhuge. Ward and Smith, PA. February 17, 2026**

“Responding can be challenging because the mere submission of a complaint can trigger a strong emotional response, and the process presents a risk that action adversely affecting the licensee may be taken. This article focuses on understanding the role and processes of licensing boards, which can help manage this challenge.”

<https://www.wardandsmith.com/article/understanding-and-responding-to-licensing-boards>

### **Aetna Agrees to Pay \$117.7 Million to Resolve False Claims Act Allegations. DOJ. March 11, 2026**

Aetna will pay \$117.7 million to resolve allegations that it submitted inaccurate and untruthful diagnosis codes for its Medicare Advantage plan enrollees in order to increase its payments, the [Department of Justice announced](#).

<https://www.justice.gov/opa/pr/aetna-agrees-pay-1177-million-resolve-false-claims-act-allegations>

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

**March 13, 2026**

“Effective 04/01/2026

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/333630ff3013/pooscgsvfh-54653?e=6d63e1c4a4>

## **Information for Commission on Paraoptometric Certification (CPC) Examinations. AOA First Look. March 13, 2026**

“Confident staff make competent staff—paraoptometric certification is how optometric practices can validate their staff’s clinical support and practice management skillsets. Make sure to use newly updated 2026 study resources, created based on the 2026 CPC exam outlines, to build staff confidence in their exam prep.

1. [2026 Paraoptometric Examination Candidate Handbook](#). Start here in preparing for a CPC exam by reading and understanding the candidate handbook. The CPO, CPOA, CPOT and CPOC outlines are included in the handbook, making it a valuable tool in knowing what to study.
2. [AOA Paraoptometric Certification Exam Study Resources](#). Use the AOA’s [study resource checklist](#) to help keep staff’s study prep on track. Majority of these resources are available in the [AOA EyeLearn Professional Development Hub](#) for AOA members and non-members.
3. [CPC 2026 Examination Schedule](#). Consult the exam schedule to know when exams are being administered in 2026.

Have you [enrolled your paraoptometrics as AOA associate members](#)? Activate this part of your AOA member benefits to grant staff access to paraoptometric programs and services.”

## **Download Your AOA Members-Only 2026 Codes for Optometry. AOA Week-in-Focus. March 19, 2026**

“The AOA now offers its 2026 Codes for Optometry & Common ICD-10 Codes card in an all-digital format, giving you free, instant access to the latest coding resources.”

[https://www.aoa.org/AOA/Documents/Secure/AOACodebook\\_2026\\_secure.pdf?utm\\_source=American+Optometric+Association&utm\\_campaign=f43368a484-](https://www.aoa.org/AOA/Documents/Secure/AOACodebook_2026_secure.pdf?utm_source=American+Optometric+Association&utm_campaign=f43368a484-)

[EMAIL CAMPAIGN 2026 03 19 04 46&utm\\_medium=email&utm\\_term=0\\_51e3bca6b0-f43368a484-7211495](#)

## **Maryland Fines Cigna \$80K, Demands Halt to Automatic Downcoding**

“The Maryland Insurance Administration [issued](#) Cigna an \$80,000 fine and is requiring the insurer to stop automatic downcoding under a recent policy, according to a March 13 letter.

Cigna’s evaluation and management policy allows the insurer to [adjust](#) some higher-level E/M codes if they do not adhere to certain complexity standards. Codes 99204-99205, 99214-99215 and 99244-99245 fall under this umbrella.

Maryland regulators determined the policy is not allowed under state law. Regulators identified payment delays, as well. Instead, Cigna must formally dispute claims it believes to be improper and request further documentation. ... “

“Downcoding is not a harmless administrative adjustment,” MedChi CEO Gene Ransom [said](#) in a March 17 statement. “It undermines physician judgment, delays payment for legitimate care and ultimately harms patients by destabilizing the physician practices that care for them.””

[https://www.beckerspayer.com/legal/maryland-fines-cigna-80k-demands-halt-to-automatic-downcoding/?origin=PayerE&utm\\_source=PayerE&utm\\_medium=email&utm\\_content=newsletter&oly\\_enc\\_id=5767J801653418J](https://www.beckerspayer.com/legal/maryland-fines-cigna-80k-demands-halt-to-automatic-downcoding/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J)

### **Healthy Mississippi Using Qualex Health Care as TPC**

Healthy Mississippi is using Qualex Health Care, a third-party administrator (TPA), for their credentialing. Healthy Mississippi – a new Medicare Advantage plan owned by the Mississippi State Medical Association. Qualex will, most likely, contact your office if you are applying to be a provider for Healthy Mississippi. You can find more information on this topic in the March 2026 Question of the Month.

Healthy Mississippi is a provider for several plans Medicare Advantage Plans including D-SNP:

Medical eye care is covered through Healthy Mississippi. Providers need to become credentialed.

Well vision, routine eye care benefits (supplemental) are covered through Avesis. Providers need to be credentialed to provide any of these benefits. Since these are supplemental benefits, patients must purchase that coverage separately.

(<https://healthy-ms.com/supplemental-benefits/>) (see below)

Provider Information can be found on: <https://healthy-ms.com/summary-of-benefits/#>

Provider manual: <https://healthy-ms.com/wp-content/uploads/2025/05/HM-Provider-Manual-2025-v5.pdf>