

April 2026 Third Party Changes of Significance

MISSISSIPPI MEDICAID

Simplified Claims Adjustment Reporting on RA. LateBreaking News. Mississippi Division of Medicaid. March 23, 2026

“Effective April 3, 2026, the Mississippi Division of Medicaid is changing how they report claims adjustments. There is no action to be taken by providers as a result of this reporting change. However, there will be updates to the accounts receivable information displayed on the Remittance Advice (RA).

Currently, the accounts receivable set up amount displayed on the CRA-TRAN-R page of the RA is the full amount of the original claim. Beginning with the RA(s) produced on April 3, 2026, all accounts receivable will be displayed on the RA with a setup amount equal to the net amount between the original claim and the adjustment claim.

The adjustment will be counted in the Claim Adjustment section of the CRA-SUMM-R when there is no claim activity to recoup from, and the account receivable amount will be included in the Accounts Receivable section of the CRA-SUMM-R when the receivable is recouped.

The original claim and adjustment claim information will still be displayed on the claims pages as they are today.”

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

Provider Termination Request Mailbox. Magnolia Health Weekly News Blast. April 10, 2026

“Effective immediately, all provider termination requests must be submitted to our new Magnolia Provider Terminations mailbox at Magnolia_Provider_Terms@Centene.com Please be sure to include the following information with your request:

- Group Name
- Group NPI
- Individual Provider Name (if applicable)
- Individual NPI
- Reason for Termination
- Effective Date of Termination

This updated process is designed to help us better monitor and track termination requests, improving communication and ensuring that all requests are accurately assigned and completed in a timely manner. Thank you for your cooperation in implementing this change.

Additionally, please note that if you are a MSCAN or CHIP provider, you should also notify the Division of Medicaid of any changes.”

<https://mailchi.mp/99deb40cdb02/pooscgsvfh-56039?e=6d63e1c4a4>

Upcoming Provider Orientations. Magnolia Health Weekly News Blast. April 17, 2026

To attend, please select the appointments link to register.

MSCAN and CHIP Medical	5/6/2026	9:00AM-10:00AM	MSCAN and CHIP New Provider Orientation Join meeting in Teams Microsoft Teams
MSCAN and CHIP Medical	5/20/26	10:00AM-11:00AM	MSCAN and CHIP New Provider Orientation Join meeting in Teams Microsoft Teams

MSCAN and CHIP Medical	6/4/2026	9:00AM-10:00AM	MSCAN and CHIP New Provider Orientation Join meeting in Teams Microsoft Teams
Ambetter Medical and BH	5/7/2026	1:00PM-2:00PM	Ambetter by Magnolia Health New Provider Orientation Meeting-Join Microsoft Teams
Ambetter Medical and BH	5/21/26	9:00AM-10:00AM	Ambetter by Magnolia Health New Provider Orientation Join meeting in Teams Microsoft Teams
Ambetter Medical and BH	6/11/26	9:00AM-10:00AM	Ambetter by Magnolia Health New Provider Orientation Join meeting in Teams Microsoft Teams
Ambetter Medical and BH	6/25/26	9:00AM-10:00AM	Ambetter by Magnolia Health New Provider Orientation Join meeting in Teams Microsoft Teams

<https://mailchi.mp/29e2d960bf5b/pooscgsvfh-56488?e=6d63e1c4a4>

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<https://mailchi.mp/29e2d960bf5b/pooscgsvfh-56488?e=6d63e1c4a4>

Provider Enrollment Consolidation Initiative. Late Breaking News. DOM. April 22, 2026

“The Mississippi Division of Medicaid (DOM) will be implementing a system update to consolidate multiple active enrollments for individual providers who share the same NPI and taxonomy into a single enrollment record.

This action is being taken to address claims processing issues where system logic is unable to establish a one-to-one match with the rendering provider, which may result in claim denials or rejections.

As part of this process, all associated group affiliations will be retained and merged under the consolidated enrollment as well as the most current credentialing and revalidation data.

No action is required from providers at this time. However, following this consolidation, providers who experience any issues accessing their provider portal account should contact their Gainwell Provider Field Representative for assistance.

As a reminder, providers are encouraged to review the demographic information within the “Characteristics” section of their provider portal account and make any necessary updates, including addresses and other key data elements, to ensure records remain accurate and up to date.

DOM will provide additional guidance if any provider-specific follow-up is needed. We appreciate your cooperation as we work to improve claims processing accuracy and efficiency.

For questions or situations not addressed in this guidance, please contact your [Field Representative](#).”

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

CMS, NOVITAS, RAILROAD MEDICARE

Evaluation and Management Services & Intravitreal Injections: Bill Correctly. CMS MLN Matters. April 3, 2026

“In a [report](#), the Office of Inspector The Mississippi Division of Medicaid (DOM) will be implementing a system update to consolidate multiple active enrollments for individual providers who share the same NPI and taxonomy into a single enrollment record.

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

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://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-april-2-2026#_Toc225948808

Video Library. Railroad Medicare - Palmetto GBA. August 18, 2025

“View past webinars at your convenience through our Video Library. A one-time registration is all that's needed. Once registered, you'll have permanent access.”

<https://palmettogba.com/jjb/did/e0ba2aseql?cat=jjb-events-and-education#ls>

Palmetto GBA to Change Banks. Railroad Medicare - Palmetto GBA. April 9, 2026

“Effective April 27, 2026, Palmetto GBA will be changing banks from Citibank to JPMorgan Chase. To minimize issues in the provider/beneficiary community, please make sure that all received checks issued from the Citibank account are deposited timely prior to the closure of our Citibank account on June 30, 2026. Please review this information and share it with appropriate staff.”

<https://palmettogba.com/jjb/did/trn8025ij8?cat=jjb-medicare-news#ls>

Unsolicited Voluntary Refunds. Railroad Medicare – Palmetto GBA. April 20, 2026

“The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.”

<https://palmettogba.com/jib/did/jauo2zjttht?cat=jib-medicare-news#ls>

CMS Responds to AOA Concerns in MA and Part D Final Rule. AOA News for Volunteers. April 10, 2026

“Last week, the Centers for Medicare & Medicaid Services (CMS) issued [their Contract Year 2027 Medicare Advantage and Part D Final Rule](#). The AOA had strongly opposed the proposal to remove the Diabetes Eye Exam measure from the Star Ratings program, emphasizing that it is a clinically meaningful metric and that current performance variability shows continued monitoring is necessary. We cautioned that removing this exam would undermine confidence in the program and signal that diabetic eye care is less important. CMS recognized AOA’s concerns and is retaining the Diabetes Care—Eye Exam measure in the Star Ratings program. CMS noted that continued inclusion of this measure will help maintain plan accountability, support access, and encourage care coordination.

The AOA also supported CMS’s decision to eliminate the Mid-Year Supplemental Benefits Notice, citing concerns that it could confuse beneficiaries, but emphasized the need for better, more innovative ways to improve awareness of coverage. We highlighted dissatisfaction among MA patients, many of whom are confused about benefits, experience delays in needed eye care, and face added complications from subcontracted vision plans that make accessing services more difficult. After consideration of the comments received, CMS will move forward with the proposal to eliminate the Mid-Year Supplemental Benefits Notice, acknowledging that it could confuse or mislead beneficiaries.”

Federal Report Provides Green Light for VBM Accountability Legislation. AOA News for Volunteers. April 12, 2026

“In its [newly released report examining the vision benefit middleman \(VBM\) industry](#), the Government Accountability Office (GAO)—Congress’ independent investigative arm—has, for the first time, documented the structure and concentration of control in the marketplace, spotlighting the urgent need for comprehensive reform.

The GAO’s findings reveal extraordinary levels of market power dominance and limited transparency. In some states, the three largest VBMs control as much as 95.5% of the employer-based vision benefits market, with a single plan controlling more than 80% in certain states.

Even at the median level nationwide, the three largest VBMs control more than three-quarters of the group market. In the individual market, concentration is even higher—reaching as much as 98.8% market control by the three largest plans in some states. The findings underscore serious concerns among policymakers in the nation’s capital and in state capitals about ensuring competition, accountability and patient choice within the vision benefits system. Read more from the AOA [here](#).”

New Medicare Physician Pay Legislation Introduced. AOA News for Volunteers. April 10, 2026

“A bipartisan bill introduced this week would give the CMS more flexibility to adjust payments to doctors of optometry and other physicians while capping the scale of year-to-year rate changes.

The Provider Reimbursement Stability Act (H.R. 8163) comes amid calls from the AOA and other physician organizations for lawmakers to address pay cuts mandated by existing statute. Most physicians saw a 2.9% pay cut in 2025, but a 3.3% increase in 2026 (including a one-year, 2.5% bump in the One Big Beautiful Bill Act), and are scheduled for a 2.2% decline in 2027.

The new bill would increase a longstanding budget-neutrality threshold from \$20 million to \$54.3 million, with a mechanism to increase the threshold every five years with medical expense inflation—giving CMS more wiggle room when adjusting prices for individual services without triggering a requirement to pay for the changes with corresponding cuts.

Additionally, it allows CMS to better correct botched estimates on the use of codes without triggering separate pay cuts due to budget neutrality requirements. Other areas of the bill would limit changes in the conversion factor, or the amount that Medicare pays per work relative value unit (RVU), to 2.5%, in order to give practices more predictability when budgeting. Further, it instructs CMS to update the direct costs it uses to calculate practice expense RVUs every five years.”

Interactive Voice Response User Guide. Railroad Medicare- Palmetto GBA. April 14, 2026

“The Interactive Voice Response (IVR) can be accessed at 877-288-7600. To view or download a copy of the updated Railroad Medicare IVR User Guide, access on the file at the beginning of this updated article.”

<https://palmettogba.com/rr/did/7gnlka5734?cat=rr-customer-service#ls>

711 Service to Replace Railroad Medicare's TTY/TTD Telephone Line. Railroad Medicare – Palmetto GBA. April 29, 2026

“Palmetto GBA Railroad Medicare will start using 711, a relay service that assists individuals with hearing or speech disabilities, to replace teletypewriter (TTY) functionality. As part of this change, we will discontinue the TTY lines and transition to the 711 service, effective June 1, 2026. Please review this announcement and share it with your staff.”

<https://palmettogba.com/rr/did/l8ncdr5kc0?cat=rr-customer-service#ls>

CMS Phases Out Some Faxed, Mailed Documentation—What Doctors Need To Know. AOA First Look. April 24, 2026

“The Centers for Medicare & Medicaid Services (CMS) will phase out the use of fax and mail for claims-related documentation in favor of a more streamlined electronic transaction process.

[Under a new final rule](#), the CMS will require HIPAA-related entities to adopt electronic standards for “claims attachments,” the supplemental documentation that health plans often request to process claims, such as medical records, clinical notes, telemedicine visit documentation and more.

For optometry practices, this shift signals a significant operational change but not a complete end to fax. The rule is narrowly focused on claims attachments but not prior authorizations or general communications.

Compliance isn’t required until May 26, 2028; however, the CMS urges providers to begin preparations now as health plans roll out implementation.

[The AOA developed a detailed FAQ](#) to break down exactly how this rule impacts doctors of optometry, including what’s being phased out, what’s not and what steps you should take next. “

<https://www.aoa.org/AOA/Documents/Practice%20Management/practice%20resources/2026%20CMS%20Fax%20Rule%20FAQ.pdf>

Medicare Change Request 14355: Internet-only Update Related to Individuals in the Custody of a Penal Authority. Railroad Medicare – Palmetto GBA. April 23, 2026

“This article includes details of the updates to the Internet-only Manuals related to individuals in the custody of a penal authority, as per Change Request 14355. Please review and share with appropriate staff.

In the CY 2025 OPPS rule, CMS clarified its regulations at 42 CFR 411.4(b) by stating that for purposes of Medicare payment

Individual is considered to be in the custody of a penal authority if the individual is:

- A. Incarcerated in a jail, prison, penitentiary or similar institution;
- B. Temporarily outside of a jail, prison, penitentiary or similar institution on medical furlough or similar arrangement;
- C. Escaped from confinement by a penal authority; or
- D. Required to reside in a mental health facility under a penal statute or rule

Individuals who are **not** considered to be in the custody of a penal authority include, but are not limited to, individuals who are:

- A. Released to the community pending trial (including those in pretrial community supervision and those released pursuant to cash bail);
- B. On parole;
- C. On probation;
- D. On home detention or home confinement; or
- E. Required to live in a halfway house or other community-based transitional facility

Medicare Change Request 14355 contains the changes CMS is making to the following Internet-only Manual (IOM) sections in order to make them consistent with 42 CFR 411.4(b):

IOM Pub. 100-02, Medicare Benefit Policy Manual, [Chapter 16](#)

- o Section 40 — No Legal Obligation to Pay for or Provide Services
- o Section 40.7 — Individuals in Custody of a Penal Authority
- o Section 50.3.3 — Examples of Application of Government Entity Exclusion

IOM Pub. 100-04, Medicare Claims Processing Manual, [Chapter 1](#), Section 10.4 — Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority

Please use the links below to review the Change Request in its entirety:

[CR14355](#): Updates to the Medicare Benefit Policy Manual (PDF)

[CR14355](#): Updates to the Medicare Claims Processing Manual (PDF)”

<https://palmettogba.com/rr/did/cnhtlmsr7q?cat=rr-claims#ls>

Who [Is the] MAC Medical Director for Railroad Medicare – Palmetto GBA? Palmetto GBA. April 10, 2026

“...**Miguel A. Brito, Jr., M.D., FCAP, FASCP**, serves as a Contractor Medical Director for Palmetto GBA. Dr. Brito is Medical Director of the National Railroad Retirement Board and is part of the physician team for Medicare jurisdictions J and M. Due to his expertise in Pathology and Laboratory Medicine, he is also part of the MoDx program. He is a graduate of the University of Miami and received his M.D. degree from the University of Florida. He completed his residency in Anatomic and Clinical Pathology at the Medical College of Virginia. After residency he was in the active private practice of Pathology for 33 years in several roles before becoming partner and owner of his own group for 15 years.

Dr. Brito has been involved in numerous hospital leadership roles from Chief of Pathology and Laboratory, Chief of Surgery, and President of the Medical Staff. He was a member and chairman of multiple hospital committees including Credentials, Infection control, Blood utilization and Medical Staff Executive Committee. He is a member and former Vice President and Executive committee member of the Florida Society of Pathologists, member and former state issues representative and current House of Delegates representative of the College of American Pathologists, member of the American Society of Clinical Pathologists and a Clinical Affiliate Assistant Professor of the Florida Atlantic University College of Medicine. He is a graduate of the Physician Leadership Academy of South Florida. He is certified by the National Board of Medical Examiners and is board-certified by the American Board of Pathology in the specialties of Anatomic and Clinical Pathology. He is a Fellow of the College of American Pathologists and Fellow of the American Society of Clinical Pathologists. ...”

<https://palmettogba.com/jjb/did/tunx47a7jm?cat=jjb-frequently-asked-questions#ls>

CMS Medicare Portal Exposed Some Providers’ Social Security Numbers. AOA First Look. May 1, 2026

“The [Washington Post](#) (4/30, Diamond, Ence Morse) reports that the Trump Administration “inadvertently exposed the Social Security numbers of health care providers in a database powering a new Medicare portal, The Washington Post found. The Centers for Medicare and Medicaid Services (CMS) last year created a directory to help seniors look up which doctors and medical providers accept which insurance plans.” The Post says that “a publicly accessible database used to populate the directory contains some of the providers’ Social Security numbers,” though “the files are not immediately visible to users who visit the provider directory.”

<https://www.washingtonpost.com/health/2026/04/30/medicare-portal-social-security-numbers-exposed/>

OTHER

Poll: 1 in 3 Adults Are Turning to AI Chatbots for Health Information, Equaling the Share Who Use Social Media for Health. Kaiser Family Foundation. March 25, 2026

“1 in 5 Who Use AI for Health Cite Affordability and Access Concerns as Major Reasons, Including Larger Shares of Young and Lower Income People ... About a third (32%) of adults nationally say they have turned to artificial intelligence (AI) chatbots in the past year for health information, a [new KFF Tracking Poll on Health Information and Trust](https://www.kff.org/health-information-trust/poll-1-in-3-adults-are-turning-to-ai-chatbots-for-health-information-equaling-the-share-who-use-social-media-for-health/) finds. Most who turned to AI for health information say they were in search of quick and immediate advice, though challenges affording and accessing health care also play a role, particularly for younger adults. <https://www.kff.org/health-information-trust/poll-1-in-3-adults-are-turning-to-ai-chatbots-for-health-information-equaling-the-share-who-use-social-media-for-health/>

SelectHealth Ophthalmologic Policies. December 2025

No changes to criteria.

https://biopolicy.s3.amazonaws.com/portal/0d538d5c-f7d2-44a1-ad59-8ea091012533?response-content-disposition=inline%3B%20filename%3D%22270910-5351725.pdf%22&response-content-type=application%2Fpdf&X-Amz-Content-Sha256=UNSIGNED-PAYLOAD&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAWKPIMDHTFM7SJDGK%2F20260403%2Fus-east-1%2Fs3%2Faws4_request&X-Amz-Date=20260403T114557Z&X-Amz-SignedHeaders=host&X-Amz-Expires=1800&X-Amz-Signature=2502fd56020277610b867626eba1c61283b5b71374e78a54f37fc8a7236f4503

2026 ICD-10-CM files. CDC. April 1, 2026

“These files include updates for FY 2026. Use these codes for discharges occurring from April 1, 2026 – September 30, 2026, and for patient encounters occurring from April 1, 2026– September 30, 2026.

- [April 1, 2026 Code Descriptions in Tabular Order \(ZIP\)](#)
- [April 1, 2026 Addendum \(ZIP\)](#)
- [April 1, 2026 Code Tables, Tabular and Index \(ZIP\)](#)
- [April 1, 2026 Conversion Table \(ZIP\)](#)”

Be sure to review all changes but the following are Changes of Note:

Chapter 2	Neoplasms (C00-D49)
	<i>No Change:</i> D49 Neoplasms of unspecified behavior
	<i>Delete:</i> Excludes1: neoplasms of uncertain behavior (D37-D44, D48)
	<i>Add:</i> Excludes2: neoplasms of uncertain behavior (D37-D44, D48)
Chapter 7	Glaucoma (H40-H42)
<i>No Change</i>	H40 Glaucoma
<i>No Change</i>	H40.8 Other glaucoma
<i>No Change</i>	H40.84 Neovascular secondary angle closure glaucoma
<i>Delete</i>	<u>Code first</u> the underlying condition such as:
<i>Delete</i>	central retinal vein occlusion (H34.81)
<i>Delete</i>	diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)
<i>Delete</i>	retinal ischemia (H35.82)
<i>Add</i>	<u>Code also</u> the underlying condition such as:
<i>Add</i>	central retinal vein occlusion (H34.81)
<i>Add</i>	diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)
<i>Add</i>	retinal ischemia (H35.82)

<https://www.cms.gov/medicare/coding-billing/icd-10-codes>

CVS Caremark: Oxervate (Medical Benefit) - Pharmaceutical Policy

“High Importance Update

Reviewed with changes to criteria and supplementary information.

Review date: 02/02/2026. Next review date (est.): 02/02/2027.”

https://info.caremark.com/content/dam/enterprise/caremark/microsites/dig/pdfs/pa-cf/cf_medcriteria/CF_MedCriteria_OXERVATE_2869-A.pdf

Oscar Health Insurance: Contact Lenses and Eyeglasses - Medical Policy

Pending - High Importance Update

Reviewed with changes to criteria, coding, and supplementary information.

Review date: 02/03/2026.

Effective date: 05/01/2026.

Next review date (est.): 02/03/2027.

[View Full Policy - PDF](#)

[View Full Policy - Payer Website](#)

[View Policy History](#)

<https://www.hioscar.com/medical/cg039v11>

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

April 10, 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/99deb40cdb02/pooscgsvfh-56039?e=6d63e1c4a4>

Wellcare: Important Prior Authorization Updates. Magnolia Health Weekly News Blast. April 10, 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
DME Services	No PA Required for PAR providers	Beds	E0185
		Orthotic & Prosthetic	L1951
		Supplies and Devices	E0486
Vision Services	No PA Required for PAR providers	Vision Evaluation	92004

<https://mailchi.mp/99deb40cdb02/pooscgsvfh-56039?e=6d63e1c4a4>

Tennessee Optometric Physicians Association Modernizes Scope of Practice. AOA Special Bulletin. April 15, 2026

The AOA is pleased to share that **Tennessee formally modernized its scope of optometric practice** with a primary focus on laser authority, procedural boundaries and clinical standards. **Tennessee becomes the 16th state in the nation** to authorize doctors of optometry to provide certain in-office, ophthalmic laser procedures thanks to the hard work and dedication of the Tennessee Association of Optometric Physicians (TAOP).

On April 14, Tennessee Gov. Bill Lee signed into law HB 1952 / SB 2076 to expand the state's optometric scope of practice, including:

- Authorizing laser procedures for the diagnosis and treatment of anterior eye conditions, as well as the expanded use of local anesthesia for limited treatments.
- Establishing limited laser authority (with certification) for three procedures—peripheral iridotomy, selective laser trabeculoplasty and YAG capsulotomy.
- Establishing that doctors of optometry are held to the same standard of care as other physicians performing similar services.
- Updating the defined statute to include treatment of the eye, eyelids and adnexa, as well as optometry's ability to perform aesthetic injections, such as botulinum toxin for cosmetic and therapeutic use.

Persistence In Appealing Denied Health Insurance Claims Resulted In Overturned Decisions Between 30% And 78% Percent Of The Time When Case Reached IROs, Analysis Shows. AOA First Look. April 14, 2026

“[MedPage Today](#) (4/13, Clark) reports, “Persistence in appealing denied health insurance claims resulted in overturned decisions between 30% and 78% percent of the time, when the case reached independent review organizations (IROs), an analysis of completed external appeals showed.” The analysis indicated that “among 51,394 closed cases in New York state from May 31, 2019 to Dec. 10, 2025, almost half (46.7%) of external appeals were overturned at this third level of appeal, which often involves independent physicians and other specialists.” The [findings](#) were published in a research letter in JAMA Internal Medicine.”

Study: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2847657>

Update To Our Interactive Voice Response (IVR) Phone System. Cigna Health. April 21, 2026

“We are seeing an increase in unapproved bot calls that are reaching our Provider Service Call Center advocates without proper authentication through the interactive voice response (IVR) phone system. To help reduce wait times, ensure advocates are available for legitimate calls, and protect patient information, we are adding a new step to our IVR phone system.

Callers will now be disconnected if they are unable to provide required information.

Callers will continue to be asked to:

- Enter a tax identification number (TIN), **or**
- Select the reason for the call (such as benefits, claims, or network participation), **or**
- Enter a member ID.

If none of this information is provided, the call will end. The disconnection step is new; the other steps remain part of the phone system today.

Thank you for your cooperation as we work to improve call access and reduce wait times for our provider community.”

<https://wlink.graphnet.com/maximail/viewviaweb.htm?reqinf=546522795G241481112GB986FDC768F8DAC6E9ECEA247B0D68B3>

Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes—2026. American Diabetes Foundation. December 2025, Vol.49, S261-S276.

Partial Summary of Recommendations

12.3: Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist 5 years after the onset of diabetes.

12.4 People with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis.

12.5 If there is no evidence of retinopathy from one or more annual eye exams and glycemic indicators are within the goal range, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight threatening, then examinations by an ophthalmologist will be required more frequently.

12.6 Programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration– approved artificial intelligence algorithms to improve access to diabetic retinopathy screening are appropriate screening strategies for diabetic retinopathy. Such programs need to provide pathways for timely referral for a comprehensive eye examination when indicated.

12.7 Counsel individuals of childbearing potential with preexisting type 1 or type 2 diabetes who are planning pregnancy or who are pregnant on the risk of development and/or progression of diabetic retinopathy.

12.8 Individuals with preexisting type 1 or type 2 diabetes should receive an eye exam before pregnancy as well as in the first trimester and may need to be monitored every trimester and for 1 year postpartum as indicated by the degree of retinopathy. ...”

[Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes—2026 | Diabetes Care | American Diabetes Association](#)

Aetna: Optic Nerve and Retinal Imaging Methods (Commercial) - Medical Policy. April 14, 2026

Updated without change.

https://www.aetna.com/cpb/medical/data/300_399/0344.html

Cigna To Exit ACA Business, Posts \$1.65B Q1 Profit. Becker’s Payer Issues. April 30, 2026

“Cigna is exiting the exchange business at the end of the year, the company’s [incoming](#) CEO, Brian Evanko, [said](#) during its April 30 first quarter earnings call.

“We did not make this decision lightly,” he said, adding there are no network or coverage changes associated with the update. Cigna’s individual and family plans [include](#) 369,000 lives.

The company [sold](#) its Medicare Advantage business to Health Care Service Corp. in 2025. Mr. Evanko said the divestment “enabled greater focus and investment in the remaining businesses within our portfolio, supporting our forward-looking growth path.”

https://www.beckerspayer.com/financial/cigna-to-exit-aca-individual-business-posts-1-65b-q1-profit/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J

United Health Care: Referral Requirements for Medicare Advantage HMO/HMO-POS Plans. UHC Medicare Advantage Plans. April 16, 2026

“Most UnitedHealthcare Medicare Advantage HMO plans require referrals for specialty services, supporting a primary care-led model focused on coordinated, high-quality care. We’ve seen strong adoption of these requirements and appreciate the continued partnership of our primary care network.

As we refine our processes, we’ll continue to defer adverse payment decisions related to referral requirements, extending the current grace period previously set to end April 30, 2026. We’ll share additional details as updates are implemented, including advance notice before the grace period ends.

Providers should continue submitting referrals for services scheduled on or after Jan. 1, 2026. “

“The new referral requirements do NOT apply to services provided by a:

Primary care provider ... Optometrist Ophthalmologist Optician....”

<https://www.uhcprovider.com/en/resource-library/news/2025/referral-req-specialist-services-medadv.html>