September 2026 Third Party Changes of Significance

MISSISSIPPI MEDICAID

Magnolia Health Launches Availity Editing Services (AES) for MSCAN and CHIP Providers. Magnolia Health Weekly News Blast. September 4, 2026

"In a continuous effort to make it easier to do business with us, Magnolia Health is introducing Availity Editing Services (AES) for MSCAN and CHIP. Starting November 15, 2026, Magnolia Health is partnering with Availity to return rejection messages on its behalf via AES messages. These messages will be shown 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 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 workbasket or queue reporting. If you submit claims via the Availity portal, any of these rejections will show 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. 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 users how 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 Magnolia Health Provider Engagement Representative."

https://mailchi.mp/64798be9a3f0/pooscgsvfh-62543?e=6d63e1c4a4

Vision Claims with Procedure Codes V2100-V2499, V2782-V2784. DOM LateBreaking News. September 10, 2026

The Mississippi Division of Medicaid (DOM) identified claims potentially paid incorrectly for vision codes: V2100-V2499, V2782-V2784 for claims processed between 10/01/2022 and 4/25/2025. Some of the policy limitation audits were not configured with correct time unit when counting Units Per Day. The claims were identified and reprocessed, so the correct limitation was applied. Adjustments to reprocess the payment will process and appear on your Remittance Advice (RA) dated 9/14/2026.

Providers impacted by this Mass Adjustment (MA) should submit a corrected claim for payment. In the event that the corrected claim(s) deny for timely filing, providers are reminded that in accordance with Part 200, Rule 1.8(A)(2), providers may request an Administrative Review regarding claims within ninety (90) calendar days of

the denial of a claim, when the Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired. Requests for an Administrative Review must include documentation that explains the facts that support the provider's position as to how the denied claim meets one (1) or more of the requirements in Miss. Admin. Code, Title 23, Part 200, Rule 1.8.A. and the reasons the provider believes he/she complied with Medicaid regulations, and other documentation as required or requested by DOM.

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 Q2-2026-PROVIDER-FIELD-REPRESENTATIVES_Map-and-By-County_v1.0.pdf."

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

Reprocessing and Recouping of FFS Claims Previously Paid in Error for Members Enrolled with a Managed Care Plan. DOM LateBreaking News. September 8, 2026

"The Mississippi Division of Medicaid completed a claim reprocessing project to recoup fee-for-service (FFS) claims that previously paid incorrectly for members enrolled in a managed care plan. The claims should have denied with edit 2017/EOB 0287 – *Member is enrolled in a State-contracted Managed Care Program*. This will result in a recoupment of previous incorrect payments impacting claims submitted to MESA. Impacted claims were originally processed between 10/01/2022 through 4/20/2025. Adjustments will appear on your Remittance Advice (RA) dated 8/31/2026.

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 Q2-2026-PROVIDER-FIELD-REPRESENTATIVES_Map-and-By-County_v1.0.pdf."

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

Gainwell to Implement New Claim Reconsideration Request Process. DOM LateBreaking News. September 14, 2026

"Effective Monday, September 14, 2026, Gainwell will implement the new Claim Reconsideration Request Process. The new process allows providers to submit a claim reconsideration request directly to Gainwell, through the Provider Portal, when a claim was either denied due to a coding-related issue or the claim processed with an improper payment where the claim paid differently than expected. Requests must be submitted **no later than ninety (90) calendar days from the date of the remittance advice (RA)**. Requests concerning timely filing issues or incorrect/incomplete requests will be returned to the provider with no action taken.

What Is Changing

1. **Submission Method**

All reconsideration requests must be submitted via the Provider Portal Secure Correspondence – Create New Message- Message Category – Reconsideration Request. A detailed Job Aid is available that outlines the required steps to help providers navigate the new process. Refer to the Provider Portal Reconsideration Request Job Aid for detailed instructions.

2. **Deadline for Submission**

A reconsideration request must be received within 90 calendar days from the date of the RA. Requests received outside of this timeframe will be returned to the provider with no action taken.

3. **One Claim per Request**

Only one (1) claim may be submitted with each reconsideration request.

4. **EOB Number Requirement**

The Reconsideration Request requires providers to reference the explanation of benefit (EOB) number(s) from the RA for the specific ICN. Unlike edit numbers, the EOB provides a clear explanation for the denial, helping providers better understand the issue and determine when a claim reconsideration is appropriate.

5. **Updated Denial Code Resource**

An updated resource list of denial codes, EOBs, and descriptions is located on Medicaid's website: https://medicaid.ms.gov/wp-content/uploads/2026/03/MESA-Errors_EOBs-20260304.xlsx

What Is Not Changing

1. **Timely Filing Review Requests**

There is no change to the process for Timely Filing Review Requests. Providers must continue to submit these requests directly to DOM online, by mail, or via facsimile, accompanied by a formal letter. Reference LBN dated September 22, 2025: "Important Reminder: Timely Filing Review Request."

2. **Prior Authorization (PA) Requirements**

Failure to obtain PA is not a valid reason for a reconsideration request. For PA-related issues, providers should refer to the EOB code on the RA. When needed, providers may contact the Utilization Management/Quality Improvement Organization (UM/QIO), Telligen, for assistance with PA requirements or options. Visit Telligen's Mississippi UM/QIO website to access the Qualitrac portal login at https://msmedicaid.telligen.com or call Telligen directly at 1-855-625-7709 for assistance.

Please note: Reconsideration requests should not be submitted for claim denials in relation to the following denial error codes/EOBs. This is not an all-inclusive list of denial reasons that would not be applicable to reconsideration requests."

Denial Error Category	Denial Error Code/EOB	Next Steps
Providers who are not active/eligible	1000/ 424 1002/ 1284 1007/ 40 1051/ 1109	Refer to RA and verify provider credentialing
Provider enrollment related denials	1945/ 1347 1946/ 1504 1076/ 1076 1077/ 77 1080/ 2080 1081/ 2081 1082/ 2082	Refer to RA and verify provider credentialing
Members who are not active/eligible	2002/ 1277 2003/ 0 2006/ 33 2057/ 33	Refer to RA and verify member eligibility
Claims that denied for timely filing	0512/ 841	Refer to Mississippi Medicaid Administrative Code Part 300 regarding timely filing

Prior authorization denials	3000/ 1526 3001/ 192 3006/ 3116 3014/ 1524 3100/ 3100 3101/ 3101 3102/ 3102 3103/ 3103 3104/ 3104 3105/ 3105 3106/ 3106 3107/ 3107 3111/ 3111 3112/ 3112 3113/ 3113 3114/ 3114 3115/ 3115 3117/ 3117	Refer to RA and follow-up directly with Telligen when a prior authorization issue is present
Lock-in errors	2603/ 631 2604/ 2605	Refer to RA and verify member's lock-in span
Exceeded service limits	5520/ 5320	Refer to RA and verify member's service limit utilization via MESA portal or automated voice response system (AVRS)
Pharmacy related denials	The Gainwell pharmacy call center phone number is 833-660-2402 where the Gainwell pharmacy help desk can assist with pharmacy claims and pharmacy PAs. All pharmacy claims and PA assistance should be directed to this number. The GWT pharmacy help desk is open Monday-Friday 8 a.m. – 6 p.m. CST. The GWT help desk is available 24 hours a day, 7 days a week for emergency pharmacy PA/claims issues.	

Pharmacy related denials	The Gainwell pharmacy call center phone number is 833-660-2402 where the Gainwell pharmacy help desk can assist with pharmacy claims and pharmacy PAs. All pharmacy claims and PA assistance should be directed to this number. The GWT pharmacy help desk is open Monday-Friday 8 a.m. – 6 p.m. CST. The GWT help desk is available 24 hours a day, 7 days a week for emergency pharmacy PA/claims issues.

Claim type restrictions related to Member Benefit Plans (also referred to as Aid Category)	Refer to RA and verify a member's benefit plan. See DOM's Eligibility Resource Document for a list of Benefit Plans/Aid Categories. The following member benefit plans are restricted: **Qualified Medicare Beneficiaries (QMB)** members are eligible for payment of Medicare A & B premiums, deductibles, and co-Insurance charges only. Review the claim type. **QMB member claims must be billed as Crossover Claim.** **Family Planning Waiver (FPW)** member benefits include family planning benefits only. Refer to Medicaid's website for the list of FPW covered diagnosis and procedure codes https://medicaid.ms.gov/wp-content/uploads/2022/12/Family-Planning-Waiver-Diagnosis-and-Procedure-Codes.pdf **Specified Low-Income Medicare Beneficiaries (SLMB)** members are eligible for payment of Medicare B premiums only.

	Qualified Working Disabled Individual (QWDI) members are eligible for payment of Medicare A premiums only. **Qualified Individual (QI-1)** members are eligible for Medicare B premiums only. **Healthier Mississippi Waiver (HMW) Benefit Plan** does not include long term care (including home and community-based services (HCBS) waiver services) or maternity and newborn care services.
Encounter Related Edits (Managed Care)	Reconsideration request for Managed Care Encounters edits will not be accepted via this process. Providers should report all issues to the respective CCO and exhaust their review and appeal processes prior to reporting the issue/inquiry to the Division of Medicaid. If the provider has contacted the CCO and needs further review by the Division, please click the "Managed Care Provider Inquiries and Issues Form" to submit an inquiry. • Managed Care Issues: Managed Care Provider Inquiries and Issues Form • Appeals Process – Contact the CCO. Please see the Managed Care Feedback page for more information: MississippiCAN Feedback – Mississippi Division of Medicaid

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at 1-800-884-3222 or your designated field representative.

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

MESA Portal Update: Enhanced Affiliated Provider Table Now Available. DOM LateBreaking News. September 15, 2026

"To improve usability and access to affiliated provider information, the MESA Portal has been updated with additional data fields and new functionality.

Organizational providers can now download the affiliated provider table as a CSV file for easier data management. This enhancement supports better oversight and streamlines provider administration.

New Data Elements Included in the Affiliated Provider Table:

All active and inactive providers are displayed with corresponding status effective dates

- National Provider Identifier (NPI)
- PCP Status (provider is eligible for enhanced funding following submission of the Self-Attestation Statement Increased Primary Care Service Payment form)
- Provider Taxonomy & Description
- MESA Status, including the effective dates of the status
- Eligible Programs
- Coordinated Care Organization/Managed Care Organizations (CCO/MCO) Affiliations, including begin and end dates of the affiliation
- Next Revalidation Date
- Next Recredentialing Date
- License Numbers, including license expiration dates

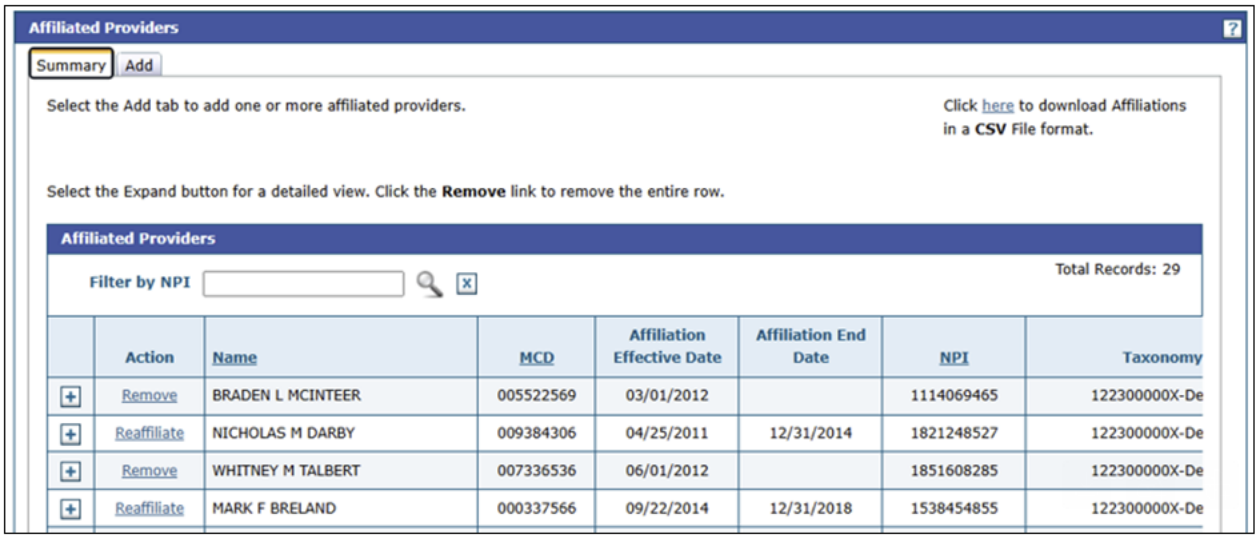
Additionally, sortable column headings (indicated by underlining) have been added for a more user-friendly experience.

Improved Affiliation Management:

Use the Actions column to easily manage affiliations:

- Click Remove to end-date a provider with an active affiliation.
- Click Reaffiliate to reinstate an inactive provider.

Please see the sample image below:



These updates are designed to make affiliation tracking and management more efficient and transparent.
https://medicaid.ms.gov/late-breaking-news/

Initial Provider Notice – Transition to Mandatory Electronic Pharmacy Prior Authorization Submission. DOM LateBreaking News. September 17, 2026

"Starting January 1, 2027, **all Mississippi Medicaid providers will be required to submit pharmacy prior authorization (PA) requests electronically** using the standardized electronic PA submission process through the Medicaid Enterprise System Assistance (MESA) Provider Portal. This update ensures full compliance with Mississippi Senate Bill 2140 (2024) and supports a streamlined, fully electronic PA submission process.

What should providers do now?

The most important step is to make sure you and your key clinic personnel have access to the MESA Provider Portal. Ensuring portal access now will help avoid delays once electronic submission becomes mandatory.

Many clinics already use the portal for PA submissions and enrollment activities such as revalidation, so your clinic administrator may already have access. Key clinic personnel responsible for submitting PA requests should confirm they have been granted delegate access from the clinic's portal administrator.

If your practice is not already registered, Mississippi Medicaid providers can register for the portal from the Division of Medicaid (DOM) website at https://medicaid.ms.gov/. … "

[More details can be found in the link below]
https://medicaid.ms.gov/late-breaking-news/

Ambetter and Medicare Request for Medical Records. Magnolia Health Weekly Blast. September 18, 2026

Magnolia Health is committed to improving the quality of care provided to our members. We are required by the U.S. Department of Health & Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), in accordance with Risk Adjustment guidelines, to submit complete diagnostic data regarding you patients, our Wellcare and Ambetter members. We do so by facilitating medical record reviews.

It is our obligation to ensure accurate and complete data is sent to federal (and, where applicable, state) regulators. Although the request for medical records is not an audit, our intention is to ensure we are aligned with our regulators for complete data accuracies.

We thank you for your participation in prior reviews and want to provide an overview of the programs that will take place over the next 12 months.

Program Logistics

	Wellcare	Ambetter
Members	MA, MMP, and DSNP Members with 2025 visits	Members with 2026 visits
Records Needed	Dates of service/encounters from January 2025 through present day	Dates of service/encounters from January 1, 2026 through December 31, 2026
Timeline for Active Outreach	June through December 2026	September 2026 through April 2027; incremental records may be requested after the initial, for the complete encounter year
Outreach Vendors	We contract with several vendors to obtain records on our behalf. You may receive outreach from Datavant, Advantmed, Datafied, Virtix, or others.	
Turn Around Time to Submit Medical Records	Outreach vendors will request the fulfillment of records within a business week. However, special accommodations can be considered.	
NOT AN AUDIT!	While we do need these records to submit diagnostic data to HHS, CMS, and state agencies,this should not be considered an audit or a claims denial exercise.	

Options for Submitting Records

Vendor: We engage several vendors to conduct reviews. A vendor representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered.

Electronic Records: Let us make it easier for you to deliver records! Our team will be happy to help reduce your administrative burden by retrieving records directly from your system. If interested in providing Magnolia Health with access to your EMR system, please complete the form in this link. https://forms.office.com/r/r9hzCxU4qR If you've already established interoperability with us, we will work to obtain the records directly.

Third Party Vendors: If you work with a third-party vendor for fulfillment of charts, please let us know in the form, so we can direct release of information requests appropriately.

Work with Us Directly: Please contact Magnolia Health for options to obtain a request list and send records directly to the health plan.

Start Now

We can obtain charts directly from your EMR. To utilize this service, complete the form and our team will begin the process to establish access.

Become familiar with the Risk Adjustment review process. Scan the QR Code below for Frequently Asked Questions regarding our record request program.

Cultural Competency Training Reminder. Magnolia Health Weekly Blast. September 18, 2026

Magnolia requires all providers to complete annual cultural competency training by **December 31st** to comply with CMS, NCQA, and state Medicaid guidelines. This training ensures we deliver equitable, respectful care, improve member communication, and maintain compliance with CMS and the DOM.

Action Required:

- Visit Magnolia Health's Provider Training Page
- Look for the **Cultural Competency** header.
- Complete the training and **submit your attestation** to receive credit.
  (Please do not forget the attestation—it's required for completion!)

If you've taken an approved cultural competency course this year, simply submit the Magnolia attestation to receive credit.

Reminder- The Cultural Competency training is an annual requirement. Please complete by **December 31st.**

If you require assistance locating the training or attestation, please contact your dedicated Provider Engagement Account Manager.

Thank you for your partnership in ensuring compliance and improving care for our members.

https://www.magnoliahealthplan.com/providers/resources/provider-training.html

Provider Termination Request Mailbox. Magnolia Health Weekly Blast. September 18, 2026

Effective immediately, all provider termination requests must be submitted to our new Magnolia Provider Terminations mailbox at Magnolia_Provider_Terms@Centene.comPlease 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.

As part of our ongoing efforts to safeguard confidential patient information and maintain HIPAA compliance, providers are reminded to review their MESA Provider Portal delegate access at least every 90 days.

MESA Provider Portal Delegate Review Reminder. DOM LateBreaking News. September 23, 2026

"Delegate access should be limited to individuals who have a current business need for access to the portal.

As part of the review, please verify that each delegate has the appropriate level of access based on their current business needs. Staff members who have left the organization or no longer require access should be removed promptly. You should:

1. Add access for new staff who have a business need
2. Adjust access when responsibilities change
3. Inactivate access when someone no longer needs it

How to Review and Update Delegate Access

1. From the MESA Provider Portal homepage, click Manage Accounts.
2. Select the Search Delegates tab.
3. Locate the delegate whose access needs to be modified or inactivated.
4. Click the delegate's name.
5. Select Inactive to remove all access, or check/uncheck the appropriate boxes to add or remove specific access.
6. Once all updates have been made, click Submit.
7. Review your changes, then click Confirm.

Please take a moment to review your MESA delegates and make any necessary updates. For more information, please refer to the Managing Delegates Job Aid or contact the Provider and Beneficiary Services Call Center at 1-800-884-3222 or your designated field representative.

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

CMS, NOVITAS, RAILROAD MEDICARE

CMS Provider Minute: The Importance of Proper Documentation Video. Railroad Medicare-Palmetto GBA. September 3, 2026

"This CMS video will help providers and physicians understand the need and importance of medical record documentation to support the services billed. Watch this video to learn more about what the CERT program has identified as leading documentation errors, and what providers and physicians can do to more thoroughly document the patient's medical record. Please share with appropriate staff."

https://palmettogba.com/jjb/did/azqjmm8484?cat=jjb-comprehensive-error-rate-testing-cert

CMS NCCI Quarterly Version Update Changes. CMS MLN Connects. September 3, 2026

RHW: No significant changes impacting Optometry noted in this update.

"Get the National Correct Coding Initiative (NCCI) first quarter edit files effective October 1, 2026, on these Medicare NCCI webpages:

- Procedure-to-Procedure Edits [Practitioner Edits Section]
- Medically Unlikely Edits
- Add-on Code Edits"

https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits

Original Medicare vs. Medicare Advantage – Revised. CMS MLN Connects. September 3, 2026

"CMS added information on prescription drug coverage (PDF)."

935 Overpayment Appeals and the Cease of Recoupment Process. Railroad Medicare - Palmetto GBA. September 9, 2026

"A 935 overpayment is a Medicare overpayment or debt that is subject to limitation of recoupment under Section 935 of the Medicare Modernization Act (MMA). This allows the provider to cease the recoupment process when a timely redetermination (first level) or reconsideration (second level) appeal is timely filed with the appropriate Medicare contractor. However, there are a few exceptions as to when Medicare can or will stop recoupment. Please review this article and share it with your staff."

https://palmettogba.com/jjb/did/icsuzp2b8c?cat=jjb-overpayments-and-recoupment

eServices Password Login Recommendation. Railroad Medicare-Palmetto GBA. September 18, 2026

"Palmetto GBA recommends logging in to eServices every 30 days to ensure your user ID is not disabled. CMS system security requirements require your password to be changed every 60 days. This is especially important if you are a provider administrator as this could also impact those account user IDs signed up under yours. Please share with appropriate staff."

https://palmettogba.com/jjb/did/9yaeza5138?cat=jjb-eservices-portal

Lunch and Learn Webinar: Tackling the Problem of Non-Response Denials, Nov. 3, 2026. Railroad Medicare-Palmetto GBA. September 18, 2026

"Event Date: 11-03 12:30 PM EST - 1:00 PM EST

Stay compliant with the Centers for Medicare and Medicaid Services (CMS) by making sure your contact information is up to date. If you're unsure, we would like to invite you to register today and join us for a repeat of this informative lunch session. Please plan to attend."

https://palmettogba.com/rr/did/eveotx5jww6ypr1103?cat=rr-events-and-education

Mississippi: $104M to Transform Rural Health Care Through Cutting-Edge Technology & Expanded Care Closer to Home. CMS MLN Connects. September 17, 2026

"This federal investment will support 167 awards to expand specialty and diagnostic care, improve health care facilities and equipment, and bring more services closer to home.

The Trump Administration announced that more than $104 million in federal Rural Health Transformation Program funding is being put to work to modernize rural health care, expand access to services, and strengthen care delivery for Mississippians. This investment will support 167 grants across rural provider technology, capital and care-gap closure, and telehealth programs. Read the full press release."

https://www.cms.gov/newsroom/press-releases/trump-administration-announces-104-million-transform-rural-healthcare-across-mississippi-through

OTHER

Aetna: Corneal Remodeling- Medical Policy 0023. Aetna. June 23, 2026

"Updated criteria for epithelium-on collagen crosslinking using FDA-approved riboflavin with ultraviolet A (Epioxa and Epioxa HD): the exclusion criterion for member ineligibility was changed from applying when the requested medication 'will be used' in conjunction with the O2n System and the Boost Goggles to applying when the requested medication 'will not be used' in conjunction with the O2n System and the Boost Goggles.

This CPB has been revised with the following changes to the medical necessity criteria for collagen cross-linking for keratoconus:

(i) to specify epithelium-off photochemical collagen cross-linkage using riboflavin and ultraviolet A (Photrexa 'and Photrexa Viscous') for the treatment of 'progressive' keratoconus and keratectasia 'following refractive surgery'

(ii) epithelium-on collagen crosslinking using FDA-approved riboflavin with ultraviolet A (Epioxa and Epoioxa HD)

a. to specify use in members 13 years of age and older;

b. to add selection requirements.**"**

https://www.aetna.com/cpb/medical/data/1_99/0023.html#dummyLink2

Aetna: Optic Nerve and Retinal Imaging Methods (Commercial) - Medical Policy 0344. Aetna. September 1, 2026

"This CPB has been updated with additional coding."

https://www.aetna.com/cpb/medical/data/300_399/0344.html#dummyLink2

BCBS Mississippi: Ophthalmologic Techniques of Evaluating Glaucoma - Medical Policy A.9.03.06. BCBS Mississippi. August 25, 2026

"Policy description updated regarding devices. Policy statements unchanged. Code Reference section updated to remove ICD-9 procedure and diagnosis codes."

https://www.bcbsms.com/policy-search/medical/policy-detail/ophthalmologic-techniques-that-evaluate-the-posterior-eye-segment-for-glaucoma

Cigna: Intraocular Lens Implant Medical Coverage Policy Number 0125. Cigna Healthcare. September 15, 2026

"Revised policy statement regarding IOL replacement to clarify lens dysfunction or failure. Updated the intraocular lens replacement criteria to add infection and lens dysfunction or failure (e.g., lens displacement, decentration, loss of fixation, optic opacification not amenable to YAG laser capsulotomy) as qualifying conditions for medically necessary replacement, in addition to the previously listed anatomical change and inflammatory response.

Updated supplementary information."

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/mm_0125_coveragepositioncriteria_intraocular_lens_implant.pdf

Cigna: Glaucoma Prostaglandins Coverage Policy Number IP0027. Cigna. August 15, 2026

"Employer Plans: Updated the Lumigan preferred product requirements.

Individual and Family Plans: Added new preferred product requirements for bimatoprost 0.01% ophthalmic solution."

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/pharmacy/ip_0027_coveragepositioncriteria_ophthalmic_prostaglandin_analogs.pdf

Cigna: Yuvezzi Ophthalmology Coverage Policy Number IP0808. Cigna. August 1, 2026

"Yuvezzi for the treatment of presbyopia is considered NOT medically necessary"

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/pharmacy/ip_0808_coveragepositioncriteria_ophthalmology_yuvezzi.pdf

Oscar: Evaluation of Dry Eyes. Oscar Health Commercial Plans G2138. Effective Date October 1, 2026.

"**III. Indications and/or Limitations of Coverage**

Application of criteria is dependent upon an individual's benefit coverage at the time of the request. Specifications pertaining to Medicare and Medicaid can be found in the "Applicable State and Federal Regulations" section of this policy document.

1) Testing of tear osmolarity MEETS CRITERIA in any of the following situations:
   a) For individuals who are suspected of having dry eye disease.
   b) To help determine the severity of dry eye disease.
   c) To monitor effectiveness of therapy.

2) For individuals suspected of having dry eye disease based on comprehensive eye examination, testing for MMP-9 protein in human tears DOES NOT MEET CRITERIA .

3) For individuals suspected of having dry eye disease, testing for lactoferrin and/or IgE DOES NOT MEET CRITERIA.

The following does not meet criteria due to a lack of available published scientific literature confirming that the test(s) is/are required and beneficial for the diagnosis and treatment of an individual's illness.

4) For individuals suspected of having dry eye disease, all other testing not discussed above DOES NOT MEET CRITERIA …

VIII. Applicable CPT/HCPCS Procedure Codes

CPT	Code Description
82785	Gammaglobulin (immunoglobulin); IgE
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity

Current Procedural Terminology© American Medical Association. All Rights Reserved.

Procedure codes appearing in Medical Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive."

https://assets.ctfassets.net/0eso7s4po5w7/4OtuS0ryaxUuGxOpmolzwK/104cf119fc6a96c1293d48c5d71c25be/G2138_-_Evaluation_of_Dry_Eyes.pdf

Molina Clinical Policy Corneal Collagen Cross-Linking (CXL) Policy No. 328. Molina Health Care. August 12, 2026

"Policy revised. Changed coverage stance pertaining to Epioxa from experimental/investigation/unproven to medically necessary. Added note to utilize Photrexa over Epioxa until supplies run out."

https://www.molinahealthcare.com/molinaclinicalpolicy/-/media/Molina/PublicWebsite/PDF/Common/Molina-Clinical-Policy/Corneal-Collagen-Cross-Linking_R.PDF

UnitedHealthCare to Participate in Mississippi's Short-Term Plans Push. Becker's Payer Issues. Elizabeth Casolo. September 1, 2026

"Mississippi Insurance Commissioner Mike Chaney confirmed UnitedHealthcare will offer short-term, limited-duration insurance through the Mississippi Comprehensive Health Insurance Risk Pool Association, with a projected start date in 2027.

The short-term plans will run for a maximum of 364 days, Mr. Chaney told *Becker's*. These plans are not ACA compliant, meaning they do not offer the same protections as individual health insurance coverage. …"

https://www.beckerspayer.com/policy-updates/unitedhealthcare-to-participate-in-mississippis-short-term-plans-push/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

Veteran Affairs: Acoltremon ophthalmic solution (TRYPTYR) National Drug Monograph August 2025

"Acoltremon is indicated for the treatment of the signs and symptoms of dry eye disease"

https://biopolicy.s3.amazonaws.com/portal/dad5d6a7-72e7-4697-a186-eaf45cfaaaed?response-content-disposition=inline%3B%20filename%3D%22385647-5153797.pdf%22&response-content-type=application%2Fpdf&X-Amz-Content-Sha256=UNSIGNED-PAYLOAD&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAWKPIMDHTFM7SJDGK%2F20260928%2Fus-east-1%2Fs3%2Faws4_request&X-Amz-Date=20260928T124548Z&X-Amz-SignedHeaders=host&X-Amz-Expires=1800&X-Amz-Signature=71668fe83729e6fc013e0346bc5a1e952168d5b30ec84036bae833bd150fa346

GOOD NEWS

At 91, Dale 'Grey Beard' Sanders Reclaims Record as Oldest Hiker to Complete the Appalachian Trail. Holly Ramer and Robert F. Bukaty. AP.

RHW: He is an Optometrist from Tennessee!!! Inspiration for us all to keep going!

"Sanders, whose trail name is Grey Beard, first set the Appalachian Trail record in 2017 at age 82. Four years later, his 83-year-old friend M.J. Eberhart, aka Nimblewill Nomad, took the title. But within months, Sanders announced his comeback plan….Sanders was born in Kentucky in 1935, two years before the Appalachian Trail was completed. Bullied as a child for his small size, he gained confidence in solo sports like acrobatics and swimming. He later served in the Navy and retired in 2002 after a long career in parks and recreation.

Sanders holds numerous other age-related records, including becoming the oldest person to paddle the entire length of the Mississippi River, an 87-day trip he started on his 87th birthday."

https://apnews.com/article/appalachian-trail-oldest-hiker-grey-beard-fd7a9a735c2cc1d31412535a2d36f6d8?utm_source=join1440&utm_medium=email&utm_placement=newsletter&user_id=66c4c7b2600ae15075a6abbe

CAUTIONARY TALES

Tenn. Optometrist Sentenced To 42 Months For $6.9M Medicare Fraud. News Channel 5 Nashville. September 14, 2026

https://www.newschannel5.com/news/tenn-optometrist-sentenced-to-42-months-for-6-9m-medicare-fraud