October 2026 Third Party Changes of Significance

MISSISSIPPI MEDICAID

No new notices pertaining to eye care for October 2026

CMS, NOVITAS, RAILROAD MEDICARE

General Appeals Information. Railroad Medicare-Palmetto GBA. October 5, 2026

"If you are dissatisfied with an initial claim determination, you have the right to request an appeal. This updated article outlines the available appeal levels, amount in controversy thresholds and the time limits for filing an appeal. Please review this information and share it with your staff."

Railroad Medicare https://palmettogba.com/rr/did/923tkd0080?cat=rr-appeals

Appeals Overview for Providers Module. Railroad Medicare-Palmetto GBA. October 6, 2026

- "In the Appeals Overview for Providers Module, you will learn the definition of an appeal; the five levels of the appeals process; appeals timeliness and amounts; who can file an appeal; what is required for filing; the way to file an appeal; and possible outcomes of an appeal. Please review this updated module and share it with your staff. Railroad Medicare"

https://palmettogba.com/jjb/did/bwfmer7485?cat=jjb-appeals

Notification of the 2027 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge Hearing or Federal District Court Review. Railroad Medicare-Palmetto GBA. October 5, 2026

"The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2026, is $200. This amount will remain $200 for ALJ hearing requests filed on or after January 1, 2027. The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2026, is $1,960. This amount will increase to $2,000 for appeals to Federal District Court filed on or after January 1, 2027. Please review and share this updated article with appropriate staff."

https://palmettogba.com/jjb/did/97kfk41765?cat=jjb-appeals

HETS: Verify Email by December 1 to Avoid Rejected Eligibility Requests. CMS MLN Connects. October 8, 2026

"If you use HIPAA Eligibility Transaction System (HETS) 270/271 to check Medicare eligibility through a software vendor, billing company, electronic health record (EHR) system, practice management system, or electronic data interchange (EDI) clearinghouse, make sure the email address on your HETS EDI Enrollment is correct by December 1, 2026. If you get a notification from your clearinghouse about an email delivery failure, or you don't get a monthly transaction count report after submitting your HETS EDI enrollment, update your email address through your Medicare Administrative Contractor (MAC) to avoid disruption (your billing company, EHR vendor, or clearinghouse can't make this change for you).

If your HETS email fails to deliver for 3 consecutive months — October 1, November 1, and December 1, 2026, HETS will suspend your HETS EDI enrollment and reject all eligibility requests submitted for your NPI. HETS will return an error until you correct your email address through your MAC."

https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system

RARCs, CARCs, Medicare Remit Easy Print & PC Print: October Update. CMS MLN Connects. October 8, 2026

"Get updated remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs). Watch for software updates if you use Medicare Remit Easy Print or PC Print.

More Information:

- Medicare Claims Processing Manual, Chapter 22, sections 40.5, 60.2, and 60.3
- Instruction to your Medicare Administrative Contractor (PDF)"

RARCs: https://x12.org/codes/remittance-advice-remark-codes
CARCs: https://x12.org/codes/claim-adjustment-reason-codes

CMS Provider Minute: The Importance of Proper Documentation Video. Railroad Medicare-Palmetto GBA. October 8, 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 QPP: Reminder: 2025 MIPS Final Scores Available

"Review your Merit-based Incentive Payment System (MIPS) final score by signing into the Quality Payment Program (QPP) website.

As a reminder:

- A final score **above 75 points** will result in a **positive (+) payment** adjustment
- A final score **equal to 75 points** will result in a **neutral (0%) payment** adjustment
- A final score **below 75 points** will result in a **negative (-) payment** adjustment

Review the following resources for more information about scoring and performance feedback:

- 2025 Quality and Cost Benchmarks
- 2025 Traditional MIPS Scoring Guide (PDF)
- 2025 MIPS Value Pathways (MVPs) Implementation guide (PDF)
- 2025 Alternative Payment Model (APM) Performance Pathways (APP) Scoring Guide, including in the 2025 APP Toolkit (ZIP)
- 2025 MIPS Performance Feedback FAQs (PDF) "

https://qpp.cms.gov/scoring-payment/final-score

CMS QPP: Reminder: 2025 Targeted Review Available

"Individual clinicians, groups, subgroups, virtual groups, Alternative Payment Model (APM) Entities (including Shared Savings Program Accountable Care Organizations (ACOs)), designated support staff and authorized third party intermediaries may request that CMS review their final score through a process called targeted review.

When to Request a Targeted Review

If you believe there's an error in the calculation of your MIPS final score, you can request a targeted review now.

- **The targeted review period will be open for approximately 60 days.**
- Targeted review opens with the release of final scores and will close 30 days after the release of MIPS payment adjustments.

We'll announce the release of MIPS payment adjustments through the QPP listserv (we anticipate these will be available in late October).

For example:

- Data were submitted under the wrong TIN or National Provider Identifier (NPI).
- You have Qualifying APM Participant (QP) status and shouldn't receive a MIPS payment adjustment.
- Performance categories weren't automatically reweighted even though you qualify for reweighting due to extreme and uncontrollable circumstances.

Note: This isn't a comprehensive list of circumstances. If you have questions about whether your circumstances warrant a targeted review, please contact the QPP Service Center by phone at 1-866-288-8292 (TRS: 711) or by email at QPP@cms.hhs.gov."

Targeted Review: https://d2g5m5leph8kam.cloudfront.net/s3fs/s3fs-public/2026-08/2025-targeted-review-user-guide.pdf?VersionId=ozMUB9iKO_nH0qSpBRZ36.pGGQetbl3E

Do I Need to Request a New MFA Code Each Time I Log In? Railroad Medicare-Palmetto GBA. October 26, 2026

"To enhance the security of Medicare data, CMS requires the use of multi-factor authentication (MFA) in eServices. After successfully entering your user name and password, you will be directed to the MFA verification screen where you will need to enter an MFA verification code to complete the login process."

https://palmettogba.com/rr/did/az3pxz5148?cat=rr-eservices-portal

Railroad Medicare - Medical Review Pre-Payment Reviews: August 2026 to July 2027. Railroad Medicare – Palmetto GBA. October 27, 2026

"An Additional Documentation Request (ADR) letter, asking for the records for a specific claim, will be sent on each claim selected for review. MR clinicians are reviewing your claim and the additional documentation which you submit. The reason for record review is to confirm that services were rendered according to the Medicare guidelines for medical reasonableness and necessity. Providers can expect review completion within 30 days of MR's receipt of the requested documentation for pre-pay claims.

A Remittance Advice (RA) will be generated after MR makes a determination on the claim. The RA will explain if the claim was allowed at the level billed, allowed but at an up-coded or down-coded level, or if the claim was denied. Railroad Medicare will also determine liability for denied services. …[**Excerpt from Table 1:]**

Type of Service	CPT®/HCPCS Code	Code Description
Ophthalmology Surgical Services	66894	Extracapsular cataract removal with insertion
Therapy	97110	Therapeutic exercises
Therapy	97112	Neuromuscular reeducation
Therapy	97113	Aquatic therapy/exercises
Therapy	97116	Gait training therapy

Resources on the Palmetto GBA Railroad Website

- Medical Review Checklist …
- Optometry and Ophthalmology Articles …
- Therapy Articles …"

https://palmettogba.com/rr/did/1cqpin3fn6?cat=rr-medical-review

Railroad Medicare - Medical Review TPE Reviews: August 2026 to July 2027. Railroad Medicare – Palmetto GBA. October 27, 2026

"Railroad Medicare's Medical Review (MR) department is currently conducting both post-payment and pre-payment Targeted Probe and Educate (TPE) reviews.

MR will mail an initial notification letter to the providers chosen for review. This letter will explain the TPE process and request a response with the name and phone number of the person who will act as the point of contact (POC) for the provider.

An Additional Documentation Request (ADR) letter, asking for the records for a specific claim, will be sent on each claim selected for review. MR clinicians will review your claim and the additional documentation which you submit. The reason for record review is to confirm that services were rendered according to the Medicare guidelines for medical reasonableness and necessity. … **Excerpts from table:**

Type of Service	CPT®/HCPCS Code	Code Description
Evaluation and Management (E/M)	99213	Office/outpatient visit, established, (Usually 20–29 minutes time)
E/M	99214	Office/outpatient visit, established (Usually 30–39 minutes time)
E/M	99215	Office/outpatient visit, established (Usually 40–54 minutes time)

Resources on the Palmetto GBA/Railroad Website

- Medical Review Checklist …
- Evaluation and Management Articles …"

https://palmettogba.com/rr/did/b2gi3pk71e?cat=rr-medical-review

Crushing Fraud, Waste, & Abuse. CMS.

"Please review this article to learn more about CMS's efforts, in crushing Fraud, Waste and Abuse (FWA). Please share this information with your staff"

https://www.cms.gov/fraud

OTHER

AOA Update: Aetna Corrects Modifier 25 Claims Edit. AOA First Look. October 22, 2026

RHW: Please note, that at this writing, only Aetna has corrected this issue. The AOA continues to address other payors and to engage with CMS and NCCI on this issue.

"Aetna implemented a system correction effective Sept. 27, 2026, related to the modifier 25 requirement. Aetna anticipates that special ophthalmological services billed with E/M services for dates of service after Sept. 27, 2026, will no longer be subject to the modifier 25 edit.

Doctors who experienced denials related to this edit should submit claims for reconsideration or appeal, as applicable, to obtain payment for affected services.

AOA continues to engage with health plans to address inappropriate modifier 25 requirements and ensure doctors of optometry are appropriately reimbursed for the services they provide."

Aetna: Corneal Remodeling Clinical Medical Policy 0023. Aetna Commercial. October 9, 2026

- "Updated covered ICD-10 codes for collagen crosslinking epithelium-off photochemical treatment: keratoconus codes narrowed from range H18.601-H18.629 to specific codes H18.621, H18.622, H18.623, and H18.629; removed Q12.0 (congenital cataract) from covered codes.
- Updated covered ICD-10 codes for collagen crosslinking epithelium-on (transepithelial) treatment: keratoconus codes narrowed from range H18.601-H18.629 to specific codes H18.621, H18.622, H18.623, and H18.629.
- Updated supplementary information."

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

Aetna: Optic Nerve and Retinal Imaging Methods (Commercial) – Medical Clinical Policy Bulletin 0344. Aetna Commercial. October 20, 2026

- "Expanded the medically necessary indications for optical coherence tomography angiography (OCTA) as an alternative to intravenous fluorescein angiography (IVFA) to include (not an all-inclusive list): diabetic retinopathy, age-related macular degeneration, retinal vascular occlusions, inflammatory eye conditions, central serous chorioretinopathy, ocular tumor evaluation, and swelling of optic nerve, in addition to the previously listed indications. The comparator was updated from fluorescein angiography (FA) to intravenous fluorescein angiography (IVFA), and a clarifying note was added describing the primary indications for OCTA and IVFA.
- Added a new experimental, investigational, or unproven criterion (item 6) stating that remote optical coherence tomography monitoring, optical coherence tomography angiography for glaucoma, and ultrasonographic optic nerve sheath assessment are experimental, investigational, or unproven for intracranial pressure conditions.
- Added HCPCS code Q5168 (injection, ranibizumab-leyk (Nufymco), biosimilar, 0.1 mg) to the other HCPCS codes related to the policy.
- Added ICD-10 codes covered if selection criteria are met for optical coherence tomography angiography (OCTA): H30.001-H30.93 (chorioretinal inflammation), H35.711-H35.719 (central serous chorioretinopathy), and H46.00-H46.9 (optic neuritis).
- Updated supplementary information."

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

Cigna to Exit ACA Individual Business, Posts $1.65B Q1 profit. Becker's Payer Issues. Jakob Emerson. October 5, 2026

Cigna is exiting the exchange in Arizona, Colorado, Florida, Georgia, Illinois, Indiana, Mississippi, North Carolina, Tennessee, Texas and Virginia, affecting about 369,000 members.

https://www.beckerspayer.com/payer/aca/6-insurers-exiting-aca-markets/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

Humana: Laboratory – Evaluation of Dry Eyes Application: Medicare Advantage Products Policy number: LAB2026003. Humana Medicare Advantage. October 2026

"Testing for matrix metalloproteinase-9 (MMP-9) protein (CPT code 83516, CPT code 83520), lactoferrin (CPT code 83520) or immunoglobulin E (IgE) (CPT code 82785) IS NOT REIMBURSABLE for any of the following: Blepharitis – Discoid lupus erythematosus – Dry eye syndrome – Epiphora – Keratoconjunctivitis – Meibomian gland dysfunction – Sicca syndrome – Visual discomfort"

https://dctm.humana.com/Mentor/Web/v.aspx?chronicleID=090009298a5ffc5c&searchID=aa57dad4-4b4f-4b7a-ac53-e0c9ae3fdd5e&dl=1&exttoken=MDkwMDA5Mjk4YTVmZmM1Y3wxNzkzMTExOTc0fDFGd25nRmhzNlh2UTNKc1IvZ01lVE1RWXZsWnRlclo0L3ZuNE9QQjJWZlU9

March Vision: Changes to Misdirected Claims Processing. March Outlook. October 22, 2026

We're updating how misdirected claims are handled. Previously, claims submitted to us in error were forwarded to the health plan for processing. Going forward, these claims will no longer be forwarded. If a claim is sent to the wrong payer, you will receive an Explanation of Payment (EOP) identifying the claim as misdirected and advising you to submit it to the correct payer.

- **New EOP code: REJMDVS**
  - Service is not payable under primary eye care benefits. Submit claim to plan for processing.

If you receive this code, please resubmit the claim directly to the appropriate health plan to avoid processing delays.

https://www.uhcprovider.com/vision/marchvision-news-misdirected-claims-change.html?cid=em-providernews-PCA12601822-oct26

March Vision: Avoid Turning Away Eligible Members. March Outlook. October 22, 2026

"Members may identify themselves by their health plan name rather than their vision network. This can create confusion during scheduling or check-in and may result in covered members being turned away unnecessarily. You play an important role in ensuring members can access care. Before declining an appointment, always verify eligibility, benefits and network status.

A quick eligibility check can make all the difference

- Don't rely solely on the name a member provides
- Verify eligibility on **providers.eyesynergy.com**
- Schedule as "pending insurance verification" when appropriate
- Contact your network representative if participation status or office availability changes

Additional resources

Check out our **Vision Brand Reminder training** for an overview of our branding, how it affects your practice and answers to frequently asked brand questions.

Working together, we can help covered members get the care they need - without delays or confusion."

https://www.uhcprovider.com/vision/marchvision-news-verify-eligibility-before-visit.html?cid=em-providernews-PCA12601822-oct26

Oscar Clinical Guideline: Xdemvy (lotilaner) (PG161, Ver. 4). Oscar Health. Effective January 1, 2027

https://cdn.sanity.io/files/jnbz686p/hioscar_production/e241118db7a726c4405d05d9acc8d1fe29ea9ec4.pdf

Tricare: Eye Surgery and Treatment - Vision Policy. Tricare. October 9, 2026

Changes to criteria and supplementary information.

https://www.tricare.mil/CoveredServices/IsItCovered/EyeSurgeryTreatment

United Health Care: What You Need to Know: New Medicaid Eligibility Requirements. United Health Care. October 26, 2026

"Beginning no later than Jan. 1, 2027, adults ages 19–64 who don't qualify for an exemption will be required to regularly demonstrate participation in work or other community engagement to maintain eligibility.

What you need to know

Some Medicaid expansion members may be required to complete qualifying work, education, training or volunteer activities, renew coverage every 6 months and provide additional eligibility documentation

State Medicaid agencies are responsible for eligibility determinations, compliance tracking and member outreach

As implementation approaches, members may have questions about these changes and how they could affect their coverage

What you can do

Encourage patients to keep their contact information current with Medicaid

Remind patients to review and respond to Medicaid notices

Direct members to their state Medicaid resources for information about eligibility, renewals and community engagement requirements

What you don't have to do

Determine Medicaid eligibility

Verify compliance with community engagement requirements

Collect documentation or make coverage decisions"

https://www.uhcprovider.com/en/resource-library/Medicaid-HR1.html?cid=em-providernews-PCA12601603-oct26

United Health Care: Corneal Topography Policy Number: MMP062.16. UHC. October 1, 2026

Date	Summary of Changes
10/01/2026	**Centers for Medicare and Medicaid Services (CMS) Related Documents** • Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version MMP062.15

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-mp/corneal-topography.pdf

Fraud Crackdown in Eye Care

What's Fueling the Fed's Ophthalmology Fraud Crackdown. Patsy Newit.Becker's ASC Review. August 4, 2026 AOA First Look. October 19, 2026

"The Becker's ASC Review (8/4, Newitt) reports that in July the Department of Justice took "at least four separate enforcement actions touching ophthalmology within about two weeks, and the cases point to three vulnerabilities baked into how ophthalmology practices generate revenue." The article describes settlements and indictments against a number of drugmakers and ophthalmic clinics, saying the "underlying allegations point to three recurring vulnerabilities rather than one bad actor." Those vulnerabilities are listed as medically unnecessary diagnostic testing, referral-based kickbacks, and "billing around the specialty's own procedures."

"The underlying allegations point to three recurring vulnerabilities rather than one bad actor:

1. **Medically unnecessary diagnostic testing…**
2. **Referral-based kickback…**
3. **Billing around the specialty's own procedures…"**

https://www.beckersasc.com/ophthalmology/whats-fueling-the-feds-ophthalmology-fraud-crackdown/