

MISSISSIPPI MEDICAID

HHS Takes Action to Provide 12 Months of Mandatory Continuous Coverage for Children in Medicaid and CHIP. September 29, 2023

Today, as part of its ongoing work to make sure all Americans have access to health care coverage, the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS), sent a letter to state health officials reinforcing that states must provide 12 months of continuous coverage for children under the age of 19 on Medicaid and the Children's Health Insurance Program (CHIP) beginning January 1, 2024. <https://www.cms.gov/newsroom/press-releases/hhs-takes-action-provide-12-months-mandatory-continuous-coverage-children-medicaid-and-chip>

MS Medicaid Provider Bulletin. Volume 31, Issue 4. October 2023

RHW: Below are the page numbers for the topics that might be of interest to Optometrists

Topics of Interest:

Page 4: Magnolia Health MississippiCAN Provider Grievance and Appeals vs. Claim Appeals

Page 5: Molina Help Finder: Helping Your Patients 24-7

“...a one-stop resource powered by FindHelp – to assist Molina members in finding the resources and services they need, when they need them, right in their communities.”

Page 6: Molina Prior Authorization

Page 8: United Health Care - Helping You Coordinate Patient Care

Includes the following:

“Diabetic Eye Exam Regular eye exam screenings for members with diabetes may help detect diabetic retinal disease. We use HEDIS guidelines to measure retinal eye exam performance for members ages 18-75 who have type 1 or type 2 diabetes. Continuity and coordination of care may be monitored through communication between the member's primary care physician (PCP) and the eye care professional performing the dilated retinal exam.”

Page 11: Provider Field Representatives List and Map and List of Regions by county

<https://medicaid.ms.gov/wp-content/uploads/2023/10/October-2023-Provider-Bulletin.pdf>

EOB 1748 – Member Birth Date does not Match File. LateBreaking News. October 23, 2023

“The Mississippi Division of Medicaid (DOM) and Gainwell Technologies are seeing an increase in medical claim denials related to Edit 2822/EOB 1748 – member birth date does not match with file, after DOM updated the claim disposition in August of 2023 to deny for all claim types. This edit/EOB will post to all claim types when the Member's birth date submitted on the claim does not match the Member's birth date in the MESA system. In order to allow providers time to adopt this change, DOM will be temporarily relaxing this edit through 11/30/2023. Providers are encouraged to resubmit impacted medical claims that posted with EOB 1748 with the corrected Member birth date.

If it is determined that a member's date of birth in MESA is incorrect, the member or their designated representative should contact their local Medicaid Regional Office to make updates. Regional Office contact information can be found at <https://medicaid.ms.gov/about/office-locations/>.

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 [Provider Field Representatives](#).”

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

Telligen to replace Alliant Health Solutions and Kepro as Medicaid UM/QIO Vendors. Latebreaking News.

October 31, 2023

“Early in 2024, the Mississippi Division of Medicaid (DOM) will transition to a new Utilization Management/Quality Improvement Organization (UM/QIO) vendor, Telligen
Telligen will replace the following vendors:

Alliant Health Solutions, who was responsible for medical authorization requests for fee-for-service (FFS) Medicaid members, and
Kepro (formerly eQHealth Solutions), who was responsible for advanced imaging authorization requests for FFS Medicaid members.

To ensure a smooth transition, Telligen web portal registration instructions and educational materials will be shared in the upcoming weeks through a variety of communication avenues to ensure no provider lacks access to necessary resources and assistance. Updates will also publicized on the [Mississippi Division of Medicaid website](#) and [Late Breaking News](#).

Please note: Prior authorizations for members enrolled in MississippiCAN and CHIP will continue to be handled by the respective coordinated care organization.”

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

CMS, NOVITAS SOLUTIONS, RAILROAD MEDICARE

2024 Medicare Parts A & B Premiums and Deductibles. CMS. October 12, 2023

“On October 12, 2023, the Centers for Medicare & Medicaid Services (CMS) released the 2024 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs, and the 2024 Medicare Part D income-related monthly adjustment amounts. ...

Each year, the Medicare Part B premium, deductible, and coinsurance rates are determined according to provisions of the Social Security Act. The standard monthly premium for Medicare Part B enrollees will be \$174.70 for 2024, an increase of \$9.80 from \$164.90 in 2023. The annual deductible for all Medicare Part B beneficiaries will be \$240 in 2024, an increase of \$14 from the annual deductible of \$226 in 2023.”

<https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles>

Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update. MM13365. Medlearn Matters.

October 19, 2023

Part B Deductible - \$240.00 a year

Part B Coinsurance - 20%

<https://www.cms.gov/files/document/mm13365-cy-2024-update-medicare-deductible-coinsurance-premium-rates.pdf>

Your Patient's Medicare Beneficiary Identifier (MBI) May Change

CMS sent letters to people with Medicare who may have been affected by a [recent data breach](#). They are mailing approximately 47,000 new Medicare cards with a new MBI to those affected. Learn what to do if your patient's MBI changes.

- ✓ [MLN8816413: Checking Medicare Eligibility \(cms.gov\)](#)
- ✓ [Welcome to Palmetto GBA eServices \(onlineproviderservices.com\)](#)

Medically Unlikely Edits (MUEs). Palmetto GBA. October 3, 2023

RHW: Please note that even though this notice was originally sent out by Palmetto GBA, this MUEs apply to all Medicare Carriers.

While the majority of MUEs are publicly available on the CMS website, CMS will not publish all MUE values. MUE Tables change quarterly; the date of the change only affects claims with dates of service (DOS) on or after the new updated tables are issued. Some MUEs allowed units are not published in the MUE table; this does not mean that there are no allowed units. It only means that CMS does not publish the allowable units for that code. Please review this updated article and share it with your staff.

<https://www.palmettogba.com/palmetto/jjb.nsf/DID/89H9LRZECK#ls>

MIPS Program Hitting Physicians With More Penalties. AOA First Look. October 6, 2023

[Axios](#) (10/5, Goldman) reports, "For years, the vast majority of physicians who participated in a Medicare program incentivizing high-quality care got payment bonuses." However, more of them "than ever are expected to soon be penalized for falling short of tougher new Medicare standards, prompting increased questions from [physicians] about the program's impact." The Merit-Based Incentive Payment System (MIPS) "was designed to get tougher as [physicians] got more accustomed to tracking quality metrics, but [physicians] say it's causing more trouble than it's worth."

Article: <https://www.axios.com/2023/10/05/medicare-doctor-pay-bonus-quality>

Quick Reference Guide, Railroad Medicare-Palmetto GBA. October 10, 2023

The Railroad Medicare Quick Reference Guide is a publication to assist providers with submitting claims to Railroad Medicare. In this guide you can find information about many Railroad Medicare topics including Provider Enrollment, submitting electronic and paper claims, using the eServices portal and the Interactive Voice Response (IVR) system, Appeals, Medical Review, Medicare Secondary Payer, Overpayments and Recoupments, and more.

<https://www.palmettogba.com/palmetto/rr.nsf/DID/7JYQ282514#ls>

Medicare Secondary Payer MLN: 006903. CMS. October 2023

New changes to MSP Program:

- Added clarification for situations where a Group Health Plan (GHP) is the primary payer but doesn't pay in full for a service (page 5)
- The Benefits Coordination & Recovery Center (BCRC) and the Commercial Repayment Center (CRC) are now referred to as the Medicare Secondary Payer (MSP) contractor (throughout)

- Added clarification for situations where Medicare Administrative Contractors (MACs) incorrectly deny claims because the services performed for an accident or injury aren't related to the liability, no-fault, or Workers' Compensation MSP occurrence found on Medicare patient records (page 9)
- Added the address of where to send Federal Black Lung Program claims (page 11)
- Added clarification about where to find the claim adjustment segment and identifying the correct claim adjustment reason code or we may deny the claim (page 12)
- Added clarification about Ongoing Responsibility for Medicals (ORM), no-fault insurance denials, and Medicare conditional payments (page 14)
- Added clarification about provider responsibilities if they discover an MSP record for a patient and how to bill appropriately (page 16)

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf

Notification of the 2024 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge (ALJ) Hearing or Federal District Court Review. Railroad Medicare Advisory. Palmetto GBA Railroad Medicare. November 2023.

"Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review. The amount in controversy is adjusted by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

- ALJ Hearing Requests — The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2023 is \$180. This amount will remain at \$180 for ALJ hearing requests filed on or after January 1, 2024.
- Federal District Court — The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2023 is \$1,850. This amount will decrease to \$1,840 for appeals to Federal District Court filed on or after January 1, 2024."

[https://www.palmettogba.com/palmetto/providers.nsf/files/November_2023_Railroad_Medicare_News.pdf/\\$FILE/November_2023_Railroad_Medicare_News.pdf](https://www.palmettogba.com/palmetto/providers.nsf/files/November_2023_Railroad_Medicare_News.pdf/$FILE/November_2023_Railroad_Medicare_News.pdf)

Unsolicited Voluntary Refunds Notification 2023. Novitas Medicare News. October 31, 2023

"As you know, providers may at times receive incorrect payment (e.g., for services/items not covered, erroneously billed, etc.). When this happens, a refund should be sent to the Medicare Administrative Contractor (MAC) by the provider. Otherwise, an overpayment, which is a debt due to the Medicare program, will be established when the error is identified by the MAC.

Medicare expects providers to exercise care when billing and accepting payment and expects that providers will promptly bring incorrect payments to the MAC's attention. These submissions acknowledge your awareness of this expectation and confirm a measure of compliance. However, please be aware that the CMS Online Manual, Publication 100-08, Chapter 4, Section 4.2.2.8.1.3 states:

"The acceptance of a voluntary refund 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."

Thank you for your efforts to work in cooperation with Novitas Solutions, Inc. to ensure proper and appropriate delivery of Medicare benefits."

<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00272508>

Monthly Reminder and Education. Novitasphere. October 27, 2023

After your office is initially enrolled for Novitasphere and the office approver sets up the organization information, an unlimited number of additional staff may request access as an end user. We do not need another enrollment form to be faxed or mailed in for any end user access requests.

For any additional staff needing access, they must create their own account and request the end user role.

Detailed instructions are linked in the steps below.

- Create a login ID and password – only needed if you have not previously created an account in the Identity Management (IDM) system. ([JH](#))
- Request the Novitasphere end user role. ([JH](#))
- Wait for your office approver to approve the request.
- Once it is approved, you may access Novitasphere. It is important to continue to access Novitasphere at least once every 30 days or your role will be removed.

MONTHLY REMINDER: All users must access Novitasphere at least once every 30 days to maintain access. Log in to Novitasphere TODAY at <https://www.novitasphere.com> to preserve your role. Any user IDs that do not sign in monthly will be considered inactive and the Novitasphere role will be removed. If you can no longer access Novitasphere due to the role removal, follow these steps to regain access ([JH](#)).

Medicare LCD and Article Updates. Medicare News. Novitas Solutions. October 27, 2023

“The following billing and coding articles have been revised to reflect the Annual ICD-10 code updates effective for dates of service on and after October 1, 2023: ...

[Billing and coding: Electroretinography \(ERG\) \(A56672\) ...”](#)

2023 Medicare Coverage Workshop Series. Medicare News, Novitas Solutions. October 27, 2023

“Stay connected with the latest Medicare information by attending our #StayConnected workshop series! Our next set of free events are focused on various aspects of Medicare policies, coverage and requirements.

Events dates and time:

Wednesday, November 1, at 10:00 a.m. ET/ 9:00 a.m. CT " Exploring National Coverage Determinations (NCDs)"

Wednesday, November 1, at 1:00 p.m. ET/12:00 p.m. CT " Exploring Local Coverage Determinations (LCDs)"

Thursday, November 2, at 10:00 a.m. ET/ 9:00 a.m. CT "Quarterly Updates to Local Coverage Determinations (LCDs)"

Thursday, November 2, at 1:00 p.m. ET/ 12:00 p.m. CT "Using the FastTrack to Medicare Coverage Policies Tool"

Friday, November 3, at 10:00 a.m. ET/ 9:00 a.m. CT " Focusing on the Beneficiary Notices Initiative (BNI)"

Register and view upcoming webinars by visiting our [Event Calendar](#). CEUs are available for successful webinar participation.”

Indian Health Services Virtual Symposium. Medicare News. Novitas Solutions. October 27, 2023

Register today! Event dates: November 7 – 9

The 2023 Indian Health Services (IHS) Virtual Symposium offers new webinars for Part A and B services. Our lineup consists of provider enrollment, inpatient and outpatient acute services overview and billing errors, professional Part B billing errors, and critical access hospital (CAH) services overview and billing errors. [Registration](#) is now open. Reserve your seat today!

OTHER

Aetna: Cataract Removal Surgery - Medical Policy 0508. August 1, 2023

Issued a new version of the document. Document history states (changes may not be limited to):

"This CPB has been revised to state that: (i) Clareon aspheric hydrophobic acrylic intra-ocular lens (IOL) is a covered, standard monofocal IOL; and (ii) light adjustable IOLs are considered non-covered, deluxe lenses. This CPB has been revised to state that the Clareon Vivity Extended Vision IOL is a non-covered deluxe lens."

https://www.aetna.com/cpb/medical/data/500_599/0508.html

Aetna: Glaucoma Testing (Commercial) - Medical Policy 0622. September 12, 2023

Reviewed with changes to criteria, supporting information, and formatting.

https://www.aetna.com/cpb/medical/data/600_699/0622.html

Cigna: Corneal Remodeling for Refractive Errors. -Policy # 0141. Effective October 15, 2023

Reviewed with changes to criteria, coding, supporting and administrative information.

Updated to new template and formatting standards. • Removed laser in situ keratomileusis, photorefractive keratectomy, and radial keratotomy from policy statement.

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/mm_0141_coveragepositioncriteria_corneal_remodeling.pdf

Humana Commercial: Azopt® (brinzolamide ophthalmic suspension) 1% Pharmacy Coverage Policy

Effective Date: January 01, 2024

Reviewed with change(s) to policy status, criteria, supporting information, administrative information, and formatting.

Criteria #1 Has had a trial with, intolerance, or contraindication to ALL of the following:

dorzolamide 2% eye drops
brimonidine 0.2% eye drops

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092987b433af>

Humana Commercial: Ophthalmic Beta Blockers Pharmacy Coverage Policy. Effective Date: January 1, 2024

New step therapy criteria.

Criteria #1 Has had previous treatment with timolol maleate eye drops, AND levobunolol eye drops.

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092987b433b4>

United Health Care Medicare Advantage: Corneal Topography Guideline Number: MPG062.11 Approval

Date: September 13, 2023

Summary of changes: Applicable Codes Removed list of applicable modifiers: LT, RT, and 50 Supporting Information Archived previous policy version MPG062.10

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-guidelines/c/corneal-topography.pdf>

Analysis Indicates Women Paid 20% More In Out-Of-Pocket Medical Expenses In 2021 Than Men. AOA First Look. October 2, 2023

“[STAT](#) (9/29, Gaffney, Subscription Publication) reported, ‘Women of all ages pay a total of \$15.4 billion more than men on annual out-of-pocket medical expenses, according to a new [report](#) from Deloitte. In 2021, that meant that women paid about 20% more than men – only 2% of which could be accounted for by maternity care.’ The ACA mandates that ‘insurers charge men and women the same premium costs.’ However, ‘the new analysis found that despite seeking more health care treatments than men, women have lower actuarial values, meaning that insurance covers less of their health claims than it does for men.’”

Report: <https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/womens-health-equity-disparities.html>

STAT article: <https://www.statnews.com/2023/09/29/female-patients-medical-expenses/>

The Medicare Advantage Marketing Problem and Where It's Headed. HealthPayer Intelligence. September 21, 2023

“Each year, Medicare’s open enrollment period starts mid-October and is preceded by an influx of marketing materials advertising private Medicare Advantage, Medicare Part D, and Medigap plans. While marketing practices are intended to inform consumers of their health plan options, many strategies have led to confusion and complaints from beneficiaries.

Since 2022, the Biden Administration has increased efforts to improve oversight of Medicare and Medicare Advantage marketing activities. Strategies to curb misleading advertising of Medicare Advantage are especially important as 50 percent of all Medicare beneficiaries are [enrolled](#) in the private program. ...

Deceptive Marketing by The Numbers: According to a [report](#) from the Commonwealth Fund, the majority of older adults received some type of plan marketing between November 30 and December 8, 2022. The survey included a nationally representative sample of 2,001 adults 65 and older.

Over three-quarters of adults reported seeing one or more television and online ads per day, while 30 percent said they received seven or more phone calls per week.

Some of the experiences that respondents mentioned would be considered fraud by federal authorities, such as a marketer asking for a beneficiary’s Medicare or Social Security number before offering plan details or calls advertising time-limited special discounts. Additionally, adults had experiences with false advertising or misleading marketing information. ...

Early Steps Toward More Oversight: In response to deceptive marketing practices and beneficiary complaints, the Senate Finance Committee has been working to increase oversight. In August 2022, Senate Finance Committee Chair Ron Wyden [requested](#) information from health insurers on Medicare Advantage marketing practices. ...

The Committee [received](#) information from 14 states and urged CMS to conduct regular oversight of Medicare Advantage marketing materials, monitor disenrollment patterns, and hold agents and brokers accountable for deceptive practices. ...

Policies In the Final Rule: In April 2023, CMS released the Medicare Advantage and Part D final rule, which included policies to increase marketing oversight. Starting in 2024, the agency will prohibit ads that use Medicare logos or other words and imagery in confusing or misleading ways. In addition, ads that do not mention a specific plan name are prohibited. ...

According to a [fact sheet](#) on the final rule, CMS reinstated protections that prevent predatory behavior and finalized changes that strengthen plans’ role in monitoring agent and broker activity. The rule also includes requirements to ensure beneficiaries receive accurate information about Medicare coverage and know how to access this information from other sources. ...

Payer Strategies for Compliance: With a slew of new marketing regulations, payers must stay on top of the changes to protect beneficiaries from misleading information. ...

Plans should ensure that their compliance activities do not operate in siloes and continuously discuss oversight policies with their marketing teams and other departments, Dillon noted. ...

Although it may be vendors and brokers who are deploying faulty marketing materials, ultimately, it is the plans’ responsibility to prevent these practices by creating oversight programs, Helaine Fingold, partner at Epstein Becker & Green, explained to HealthPayerIntelligence.”

Article: https://healthpayerintelligence.com/features/the-medicare-advantage-marketing-problem-and-where-its-headed?utm_source=nl&utm_medium=email&utm_campaign=newsletter

Feds To Crack Down On Use Of Predictive Software To Make Coverage Decisions For Medicare Advantage Patients. AOA First Look. October 6, 2023

[KFF Health News](#) (10/5, Jaffe) reports that starting next year, the Centers for Medicare & Medicaid Services will begin “restricting how Medicare Advantage plans use predictive technology tools to make some coverage decisions.” Medicare Advantage plans “are operated by private insurance companies. About half the people eligible for full Medicare benefits are enrolled in the private plans, attracted by their lower costs and enhanced benefits.” Insurance companies “receive a monthly payment from the federal government for each enrollee, regardless of how much care they need.” According to federal officials, “this arrangement raises ‘the potential incentive for insurers to deny access to services and payment in an attempt to increase profits.’” KFF Health News highlights UnitedHealthcare’s use of naviHealth to decline coverage for care traditional Medicare likely would have covered.

<https://kffhealthnews.org/news/article/biden-administration-software-algorithms-medicare-advantage/>

Vision Impairment May Be Associated with Food Insecurity. Michela Cimberle. Ocular Surgery News. October 9, 2023.

“In a sample of U.S. adults, vision impairment was associated with food insecurity, defined as ‘limited or uncertain availability of nutritionally adequate or safe foods,’” according to findings presented in a poster at an ophthalmology meeting. For the study, investigators “analyzed data from the 2011-2018 National Health Interview Survey.”

<https://www.healio.com/news/ophthalmology/20231009/vision-impairment-may-be-associated-with-food-insecurity>

Our Sense Of Smell Changes How We See Color. Holly Large. IFLScience. October 9, 2023.

“Different odors can affect how we perceive a particular color.”

https://www.iflscience.com/our-sense-of-smell-changes-how-we-see-color-71032?utm_source=join1440&utm_medium=email&utm_placement=newsletter

HHS, CISA Release Healthcare Cybersecurity Toolkit. AOA First Look. October 27, 2023

“[Healthcare IT News](#) (10/26, Fox) reports, ‘The Cybersecurity and Infrastructure Security Agency and the Department of Health and Human Services released the Cybersecurity Toolkit for Healthcare and Public Health after a discussion on cybersecurity challenges the U.S. healthcare and public health sector system [face] and how [the] government and industry can work together to close the gaps in resources and cyber capabilities.’ The new offering ‘contains remedies for healthcare organizations of all sizes and addresses cyber hygiene, tools to build strong cybersecurity foundations, and resources to strengthen defenses and stay ahead of constantly evolving threats.’”

Article: <https://www.healthcareitnews.com/news/cisa-hhs-and-hscc-release-healthcare-cybersecurity-toolkit>

Toolkit: <https://www.cisa.gov/topics/cybersecurity-best-practices/healthcare>

YET ANOTHER CAUTIONARY TALE

Laredo Ophthalmologist Charged In Repetitive Harmful Eye Procedure Fraud Scheme. Department of Justice. October 5, 2023

“... Dr. Michael Hochman made his initial appearance today and is set for arraignment Oct. 12 before U.S. Magistrate Judge Christopher dos Santos. A federal grand jury returned the five-count indictment Sept. 27.

According to court documents, Hochman is an ophthalmologist who owned and operated Michael A. Hochman P.A. and Laredo Laser & Surgery Ltd. in Laredo.

The charges allege Hochman falsely diagnosed vulnerable patients with ophthalmological diseases and various degenerative eye conditions. Hochman allegedly directed optometry staff to conduct fraudulent, repetitive and excessive medical procedures on patients to maximize profits. ...

The false and fraudulent claims Hochman allegedly submitted to Medicare, Medicaid and Tricare totaled \$402,536,174. As a result of the false and fraudulent claims, Medicare, Medicaid and Tricare paid approximately \$13,317,914, according to the charges. ...

If convicted, Hochman faces up to 10 years in prison for one count of health care fraud. He also faces four counts of money laundering, which carries a penalty of up to 20 years imprisonment. All charges also carry a possible \$250,000 maximum fine.”

<https://www.justice.gov/usao-sdtx/pr/laredo-ophthalmologist-charged-repetitive-harmful-eye-procedure-fraud-scheme>