

MISSISSIPPI MEDICAID**CMS NEW Advanced Beneficiary Notice of Non-Coverage Mandatory on June 30, 2023. CMS. April 4, 2023**

“The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. The use of the renewed form with the expiration date of 01/31/2026 will be mandatory on 6/30/23. You may continue to use the ABN form with the expiration date of 6/30/23 until the renewed form (expiration date 01/31/2026) becomes mandatory on 6/30/23. ”

Notice: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI>

ABN Form: [ABN, \(ZIP\)Form CMS-R-131 \(ZIP\)](#)

ABN Instructions: <https://www.cms.gov/medicare/medicare-general-information/bni/downloads/abn-form-instructions.pdf>

Claims Denied/Posting Edit 798. May 4, 2023

“The Mississippi Division of Medicaid advises providers to resubmit secondary claims, which previously denied for Edit 798 “TPL AMOUNT LESS THAN % SPECIFIED”, via the MESA Provider Portal or paper submission to assure these claims process accordingly.

If there is no EOB attachment and the TPL amount is less than 20%, the claim will deny with Edit 798.

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or your designated provider field representative at <https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf>.”

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

Providers and Member Registered Users: Portal Password Policy Updates. May 4, 2023

“We would like to inform you that the Portal password policy has been updated for enhanced security. As part of this update, we now require all passwords to **be at least 14 characters long**. This means that your current password may no longer be compliant with our policy, and you will need to update it accordingly. Follow the password policy requirements outlined below.

1. A password cannot be reset more than once in a 24-hour period.
2. Passwords will expire every 60 days.
3. The minimum password length is 14.
4. The password cannot repeat any of the previous 24.
5. Passwords must be complex, containing 3 of the following 4 items:
 - Upper case letters (A, B, C...)
 - Lower case letters (a, b, c...)
 - Numbers (1, 2, 3...)
 - Special characters (!, \$, * ...)
6. User ID cannot be part of your password.

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 <https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf>.”

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

[Gainwell Technologies] AVRS No Longer Requires PIN Access. Mississippi Medicaid Late Breaking News. May 16, 2023

“It has now become easier to use the Gainwell Technologies’ Automated Voice Recognition System (AVRS). The requirement to use a Personal Identification Number (PIN) for validation when using the AVRS has been

removed. Providers will now be able to retrieve claims, eligibility, payment, and service limit information without needing to supply a PIN.

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or use the Provider Field Representative list on Medicaid's website to identify your designated representative.

The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located at <https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf>." (From <https://medicaid.ms.gov/late-breaking-news/>)

Centralized Credentialing for MSCAN/MCHIP. Mississippi Medicaid Late Breaking News. May 26, 2023

"During the 2021 Mississippi Legislative Session, Senate Bill 2799 was enacted into law that requires the Medicaid Coordinated Care Organizations (CCO) to follow a uniform credentialing process for provider enrollment in the Managed Care Programs. On July 1, 2022, in accordance with this new requirement, the Mississippi Division of Medicaid (DOM) amended the CCO contracts to require the CCOs to accept DOM's provider enrollment and screening process, and not require providers be credentialed by CCOs for Medicaid or CHIP.

Beginning October 1, 2022, providers seeking participation in MississippiCAN and/or CHIP are now required to be enrolled, credentialed, and screened by DOM, and subsequently contract with their CCO of choice. As part of the implementation of the Medicaid Enterprise System Assistance (MESA), DOM implemented a new centralized credentialing process along with NCQA certified Centralized Verification Organization (CVO) that will be responsible for credentialing and recredentialing Medicaid providers seeking to enroll or currently enrolled with our coordinated care programs (MSCAN/CHIP). This new process eliminates the need for a provider to be credentialed or recredentialed multiple times.

The CVO will perform recredentialing for both current providers and new providers every three (3) years unless the provider is credentialed by a DOM-approved Delegated Credentialing Entity. Providers identified for recredentialing will receive notification from Gainwell Technologies by letter which is sent to the providers "mail to" address on their provider record. This letter is generated six months in advance of the recredentialing due date on the provider's record in MESA and a link will be available in the portal to start the process.

Facilities with multiple service locations and provider IDs will receive a recredentialing notice for each provider ID. Only one provider ID for the same tax ID and service location address will need to submit the recredentialing application which will pick up and credential all the taxonomies at that location. If recredentialing is either denied or not completed by the recredential due date, all the facility enrollments at that location will be terminated and claims can no longer be paid. A new application for each taxonomy at that service location will be required to re-enroll in the Mississippi Medicaid program.

Individual providers with multiple provider IDs sharing the same NPI will receive a recredentialing notice for each of the provider IDs. The provider will only need to recredential one of the IDs to satisfy the requirement for all. If recredentialing is either denied or not completed by the recredential due date, all the individual provider's enrollments will be terminated, and claims can no longer be paid. A new application for each service location will be required to re-enroll in the Mississippi Medicaid program.

In addition to the notices mailed by Gainwell Technologies, providers can refer to DOM's website where we are posting the Provider Six Month Recredentialing Due List" at <https://medicaid.ms.gov/>. This listing will be updated weekly. Please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 if you need assistance between the hours of 8 a.m. and 5 p.m. CST."

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

Magnolia Health - Updated Claim Dispute Process for Mississippian. May 12, 2023

“Magnolia Health is updating our Claim Appeal timeframe to align with the Division of Medicaid’s timeframe of 30 days that went into effect July 1, 2017. MississippiCAN claim appeals must be received within 30 days from the date of notification of payment or denial, rather than 90 days.

- **The First Time Claim submission timeframe will not change.** First-time clean claims must be submitted within 180 days of the member's service date.
- **The Reconsiderations process and timeframe will not change.** Reconsiderations are optional in the claim dispute process. Reconsiderations must be submitted within 90 days of the Explanation of Payment or Denial.
- **Corrected Claims timeframe will not change:** Corrected claims must be received within 90 calendar days from the notification of payment or denial.
- **UPDATE* Claim Appeal Timeframe:** Effective May 31, 2023, The Claim Appeal must be received within **30 days** from the date of notification of payment or denial.

Corrected Claims and Reconsiderations can be submitted through the Magnolia Secure Provider Portal, through your preferred clearinghouse, or by mail to Magnolia Health Attn: Corrected Claim PO Box 3090 Farmington, MO 63640-3800.

- The claim should include the appropriate resubmission code, and the original claim number or EOP must be included with the resubmission.
- Failure to include the appropriate resubmission code and original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit

Request for Claim Reconsideration can be submitted by logging into your Magnolia Secure Provider Portal or by mail to Magnolia Health Attn: Reconsideration PO Box 3090 Farmington, MO 63640-3800. Magnolia encourages providers to utilize the Secure Web portal or the **Reconsideration Dispute form** when submitting a reconsideration request.

- A request for reconsideration is a written communication from the provider about a disagreement of a processed claim.
- Request must include sufficient identifying information which includes, at minimum, the patient's name, ID number, date of service, total charges, and provider name.
- Documentation must also include a detailed description of the reason for the request.

***Important: Please note that a request for reconsideration cannot be filed after a request for a claim appeal or exhausting the claim dispute process.**

If the corrected claim or the request for reconsideration results in an adjusted claim, you will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and the next step in the claim dispute process.

Request for Claim Appeal must be submitted by mail to Magnolia Health Attn: Dispute PO Box 3090 Farmington, MO 63640-3800.

To ensure timely processing, please utilize the NEW! **Claim Appeal form** or the request must be marked as "Claim Appeal" at the top of your documentation. Request must include detailed and sufficient information, which includes the reason for the claims appeal request, the patient's name, patient ID number, date of service, total charges, and provider name.

If the request for a claim appeal is upheld or overturned, you will receive a letter detailing the decision. Please note that reconsideration cannot be filed after an appeal.

If you have questions about this process or want to receive education related to the changes, don't hesitate to contact Provider Services at 1.866.912.6285 or your Provider Engagement Representative.

Magnolia Health - *Outpatient Clinical Documentation, Medical Necessity Criteria, Treatment Planning, and Smart Goal Format Training* . May 12, 2023

“Magnolia presents Outpatient Clinical Documentation, Medical Necessity Criteria, Treatment Planning, and SMART Goal Format Training

Registration URL: <https://attendee.gototraining.com/rt/5402697104519494146>

Description

This is a live event. Attendees will need to log into the GoToTraining room 15 minutes prior to start & connect to audio via their device or call the conference number.

This training will describe the treatment journey and identify skills to assist with engagement techniques for information gathering as well as the importance of reflecting medical necessity criteria (MNC) in the clinical documentation and treatment plan utilizing SMART Goal format.

Learning objectives for this training are:

1. Identify evidence-based practices used when treatment planning
2. Explain best practices for treatment planning and documentation
3. Describe Medical Necessity Criteria (MNC) and the importance of reflecting MNC in the clinical documentation
4. Describe SMART Goal format and discuss how SMART format helps connect documentation, MNC and measurement of member progress.
5. Discuss when discharge planning starts and why it is important to address throughout treatment

Training Schedule:

June 13th 10:00 – 11:30 CDT

June 15th 2:00 – 3:30 CDT

<https://attendee.gototraining.com/rt/5402697104519494146>

CMS, NOVITAS, RAILROAD MEDICARE

Electronic Billing Is Smart – And Getting Even Smarter. April 26, 2023

“Novitas Solutions will soon be introducing Smart Edits to our electronic billing systems. The new Smart Edits will alert providers of any claims that can be repaired quickly - only one business day after electronic submission.

Think of how much sooner you could be getting your Medicare claim payments!

Electronic billing can be done completely free using PC-ACE and Novitasphere. PC-ACE is the software available to create the electronic claim files. Novitasphere is the online portal available to submit the electronic claim files and response reports (along with many other useful [features](#)).

Not enrolled yet? The [Novitasphere Enrollment eGuide](#) will walk you through the steps needed to gain access.

This eGuide also includes links to the forms, systems, and instructions to make getting started simple. The option to request the PC-ACE software is on the Novitasphere enrollment form.”

Smart Edits – coming soon. Novitas Solutions. May 26, 2023

“We previously announced the introduction of Smart Edits to our electronic billing systems. This enhancement will alert providers of any claims that can be repaired prior to a denial. The messages will display on the 277CA electronic claims acknowledgement response report and may require the claim to be resubmitted. Smart Edits is being introduced in two phases:

- **Phase 1** (Effective now) : Education mode – Review the [Smart Edit lists](#) and make any necessary corrections to your billing practice now, so claim will not be rejected once the edits are turned on in Phase 2.
- **Phase 2** (Date to be determined): Claims processing mode – The Smart Edits will be implemented. When errors are found, the claim may reject before entering the claim processing system and may require the claim to be resubmitted.

See how much time these Smart Edits will save with a comparison example of the [electronic claim flow](#) with and without Smart Edits.

Do you receive the 277CA report after submitting your electronic files? If not, you will need to start retrieving them or find out who in your office is retrieving them for you now. This report information is essential to

understanding and tracking the electronic claim billing process. A training module is available on our website: [Understanding the 277CA Claims Acknowledgement](#).

Continue to monitor your email and the [Smart Edits web page](#) for more information on Phase 2 Implementation. <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00275505> “

Statement from the DEA Administrator Anne Milgram on COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications. DEA. May 3, 2023

“The Drug Enforcement Administration received a record 38,000 comments on its proposed telemedicine rules. We take those comments seriously and are considering them carefully. We recognize the importance of telemedicine in providing Americans with access to needed medications, and we have decided to extend the current flexibilities while we work to find a way forward to give Americans that access with appropriate safeguards.

For this reason, last week, DEA, in concert with the Department of Health and Human Services, submitted a draft Temporary Rule to the Office of Management and Budget entitled ‘Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications.’ Further details about the rule will become public after its full publication in the Federal Register.”

<https://www.dea.gov/documents/2023/2023-05/2023-05-03/statement-dea-administrator-anne-milgram-covid-19-telemedicine>

Billing and Coding: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow A57618. Novitas Solutions. Revision Effective Date - 06/25/2023

RHW: Substantive changes made. Review this new article in full.

“Update to correct coding guidance and ICD-10-CM codes that were not in alignment with the LCD indications.”

<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57618&ver=21&contractorName=6&contractorNumber=all&updatePeriod=1041&sortBy=updated&bc=13>

Prolonged Physician Services: Office and Other Outpatient Evaluation and Management (E/M) Visits

RHW: Guidance on billing prolonged physician services when necessary for E&M codes reviewed in depth. You must determine the 99205 or the 99215 services level using time and not medical decision making in order to use G2212.

“CMS created the new HCPCS code G2212 to bill Medicare for prolonged E/M services which exceed the maximum time for a level five office/outpatient E/M visit by at least 15 minutes on the date of service. Effective January 1, 2021, CMS created HCPCS code G2212 for prolonged office/other outpatient evaluation and management (E/M) visits. HCPCS code G2212 is to be used for billing Medicare for prolonged office and outpatient E/M visits instead of CPT codes 99358, 99359 or 99417, for dates of service on and after January 1, 2021.”

<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00081586>

Merit-based Incentive Payment System (MIPS) Automatic Extreme and Uncontrollable Circumstances (EUC) Policy Applied to MIPS Eligible Clinicians in Designated Areas of Mississippi. CMS. May 22, 2023

“In response to the *Mississippi Severe Storms, Straight-Line Winds, and Tornadoes* disaster, as identified by both a Health and Human Services (HHS) Public Health Emergency (PHE) [declaration](#) and a Federal Emergency Management Agency (FEMA) disaster declaration ([DR-4697-MS](#)), the Centers for Medicare & Medicaid Services (CMS) has determined that the MIPS automatic EUC policy will apply to MIPS eligible clinicians in designated areas of Mississippi.

MIPS eligible clinicians in these areas will be automatically identified and have all 4 performance categories reweighted to 0% during the data submission period for the 2023 performance period (January 2 to April 1, 2024). This will result in a score equal to the performance threshold, and they'll receive a neutral payment adjustment for the 2025 MIPS payment year.

However, if MIPS eligible clinicians in these areas submit data on 2 or more performance categories, they'll be scored on those performance categories and receive a 2025 MIPS payment adjustment based on their 2023 MIPS final score.

NOTE: The MIPS automatic EUC policy doesn't apply to MIPS eligible clinicians participating in MIPS as a group, subgroup, virtual group, or Alternative Payment Model (APM) Entity. However, groups, virtual groups, and APM Entities can request reweighting through the EUC Exception application. Subgroups can contact the Quality Payment Program (QPP) Service Center to request reweighting.

For More Information

Please reference the MIPS EUC Exception section on the [QPP Exception Applications webpage](#) and review the [2023 MIPS Automatic EUC Policy Fact Sheet](#).

OTHER NEWS

Aetna Contact Lenses and Eyeglasses. Medical Clinical Policy Number 0126. Revised March 23, 2023

RHW: Please read this policy to ensure you understand coverage that is allowed.

"Most Aetna medical benefit plans exclude coverage of contact lenses and other vision aids. Please check benefit plan descriptions for details. These benefit plans do not cover contact lenses or scleral lenses for correcting astigmatism associated with keratoconus or other corneal disorders under medical plans that exclude coverage of contact lenses and eyeglasses. This includes corneal contact lenses and scleral lenses that may be prescribed for masking irregular astigmatism associated with corneal ectasia (e.g., keratoconus, keratoglobus, pellucid corneal degeneration, Terriens marginal degeneration, post-LASIK ectasia), post-operative astigmatism (e.g., following refractive surgery or corneal transplant), corneal scarring (e.g., from trauma, infection, or Hydrops), and anterior corneal dystrophies (e.g. Meesman's, Cogan's). Contact lenses and scleral lenses provided to members with keratoconus and other corneal disorders associated with irregular astigmatism are covered under the provisions of the member's vision care plan only."

https://www.aetna.com/cpb/medical/data/100_199/0126.html

Aetna Computerized Corneal Topography. Number 0130. Revised March 24, 2023

"Aetna does not cover computerized corneal topography if it is performed pre- or post-operatively in relation to a non-covered procedure (i.e., refractive eye surgery). Most Aetna benefit plans exclude coverage of refractive surgery. Please check benefit plan descriptions for details."

https://www.aetna.com/cpb/medical/data/100_199/0130.html

Aetna Graves' Ophthalmopathy Treatments. Medical Clinical Policy Bulletin Number: 0419. Reviewed 04/27/2023

"Reviewed with changes to criteria, supplementary information, and formatting.
Added Tepezza dosing requirement initial approval criterion;
Added Tepezza repeat infusions exclusion criterion;
Updated Graves' Ophthalmopathy experimental and investigational criteria;
Updated Tepezza precertification notation;
Updated supporting and administrative information;
Revised policy with minor formatting changes."

https://www.aetna.com/cpb/medical/data/400_499/0419.html

Aetna Visual Evoked Potential Coverage Policy. Number 0181. Revised April 7, 2023

RHW: Please note this policy is embedded within Evoked Potential Studies policy

"Considered medically necessary for any of the following indications:

1. To diagnose and monitor multiple sclerosis (acute or chronic phases); *or*
2. To evaluate signs and symptoms of visual loss in persons who are unable to communicate (e.g., unresponsive persons, etc); *or*

3. To identify persons at increased risk for developing clinically definite multiple sclerosis (CDMS); *or*
4. To localize the cause of a visual field defect, not explained by lesions seen on CT or MRI, metabolic disorders, or infectious diseases.

Standard or automated VEPs are considered experimental and investigational for routine screening of infants and other persons; evidence-based guidelines from leading medical professional organizations and public health agencies have not recommended VEP screening of infants. VEPs are considered experimental and investigational for all other indications because their effectiveness for indications other than the ones listed above has not been established.”

https://www.aetna.com/cpb/medical/data/100_199/0181.html

Ambetter Prepayment Claim Reviews. Ambetter 6/5/2023

“Ambetter is committed to continuously improving its overall payment integrity solutions to prevent overpayments due to waste or abuse. This is a notification that we will begin performing additional prepayment claim reviews on 6/5/2023 using Optum’s Comprehensive Payment Integrity (CPI) tool. As a result of these prepayment claim reviews, providers may be asked for medical records and billing documents that support the charges billed.

Ambetter utilizes widely acknowledged national guidelines for billing practices and supports the concept of uniform billing for all payers. These prepayment claim reviews will look for overutilization of services or other practices that directly or indirectly result in unnecessary costs. A provider’s order must be present in the medical record to support all charges, along with clinical documentation to support the diagnosis and services or supplies billed.

The provider will receive detailed instructions about how to submit the requested documentation. Providers who do not submit the requested documentation may receive a technical denial, which will result in the claim being denied until the information required to adjudicate the claim is received.

If it is determined that a coding and/or payment adjustment is applicable, the provider will receive the appropriate claim adjudication. Providers retain their right to dispute results of reviews.

Please contact your Provider Services representative if you have any questions.”

BCBS Federal Employee Plan. Cyclosporine Ophthalmics. Effective April 1, 2023

No changes to criteria.

https://www.fepblue.org/-/media/FEPBlue-Sitecore-10-Media/PDFs/04-01-2023/Phar%20Policy%20Remove%20and%20Replace/5_90_022%20Cyclosporine%20Ophthalmics.pdf

BCBS Federal Employee Plan. Xiidra. Effective April 1, 2023

No changes to criteria.

<https://www.fepblue.org/-/media/FEPBlue-Sitecore-10-Media/PDFs/04-01-2023/Phar%20Policy%20Remove%20and%20Replace/590023%20Xiidra%20lifitegrast.pdf>

BCBS Federal Employee Plan, CVS Caremark: Cyclosporine Ophthalmics - Prior Authorization (PA) Rationale

Updated Rationale for prior approval requirement

https://www.caremark.com/content/dam/enterprise/caremark/microsites/dig/pdfs/pa-fep/fep-rationale/FEP_Rationale_Cequa.pdf

Centene: Clinical Policy: Corticosteroids for Ophthalmic Injection (Dextenza, Iluvien, Ozurdex, Retisert, Xipere, Yutiq) Reference Number: CP.PHAR.385 Effective Date: 09.01.18 Last Review Date: 05.23 Line of Business: Commercial, HIM, Medicaid

RHW: Note this includes Magnolia Health Plans

“Reviewed with changes to applicable drug, coding, drug information, and supplementary information.
Added Dextenza with associated criteria;
Added codes J1096 and J3299;
Updated drug information tables;
Updated supporting information.”

<https://www.centene.com/content/dam/centene/policies/pharmacy-policies/CP.PHAR.385.pdf>

Clinical Policy: Bimatoprost Implant (Durysta) Reference Number: CP.PHAR.486 Effective Date: 06.01.20

“Reviewed with changes to supporting information, administrative information, and formatting.
No changes to criteria.”

<https://www.centene.com/content/dam/centene/policies/pharmacy-policies/CP.PHAR.486.pdf>

Clinical Policy: Cyclosporine (Cequa, Restasis, Verkazia) Reference Number: CP.PMN.48 Effective Date: 05.01.12

“Reviewed with changes to supporting information.
No changes to criteria.”

<https://www.centene.com/content/dam/centene/policies/pharmacy-policies/CP.PMN.48.pdf>

Cigna: Policy Updates - News & Announcements – April 15, 2023

Payer has announced various new policies, retired policies, criteria, coding, coverage, drug information, and supporting information changes. Please refer to the attached bulletin for complete information.
Changes include:

[Headache, Occipital and/or Trigeminal Neuralgia Treatment – \(0063\)](#)

[Remote Patient Monitoring \(RPM\) and Remote Therapeutic Monitoring \(RTM\) – \(0563\)](#)

<https://static.cigna.com/assets/chcp/resourceLibrary/coveragePolicies/policyUpdates/coveragePoliciesLatestUpdatesApril2023.html>

[CIGNA] Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service. Reimbursement Policy M25. Notice May 25, 2023.

RHW: Cigna had intended to implement a change that would have required submission of documentation to support the use of modifier 25 when billed with E/M CPT codes 99212 – 99215 and a minor procedure. However, this decision has apparently been delayed after receiving strong pushback from the AOA, the AMA, and other medical groups opposing this policy.

“Notification: Cigna will delay the implementation to require the submission of documentation to support the use of modifier 25 when billed with E/M CPT® codes 99212 – 99215 and a minor procedure. Cigna will continue to review for future implementation.”

https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/Modifier_25_Significant_Separately_Identifiable_Evaluation_and_Management.pdf

Humana Medicare Ophthalmic Cyclosporine (Cequa™, generic Restasis)- Pharmacy Policy April 26, 2023

“Reviewed with changes to criteria and supplementary information.

Updated criteria for dry eye disease to add note that previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option;

Updated supporting information.”

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092986a1e554>

Humana: Glaucoma Surgical Treatments - Medical Policy Number: HUM-0475-029 Effective Date: 04/27/2023

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

Added canaloplasty criterion inability to administer medical therapy or adhere to the schedule required due to cognitive or physical impairment;

Added coverage statement for trabeculectomy, trabeculoplasty, iridotomy, iridectomy and/or iridoplasty;

Added coverage statement for Ahmed glaucoma valve, Baerveldt glaucoma implant, Krupin eye valve and Molteno implant;

Updated some coding descriptions;

Updated supporting information.

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092986a55e6f>

Humana: Xiidra (Medicare) - Pharmaceutical Policy. Revision Date: April 26, 2023

Reviewed with changes to criteria and supplementary information.

Updated criteria for dry eye disease to add that previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option;

Updated administrative information.

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092986a1e558>

Humana: Simbrinza (Commercial, Medicare) - Pharmaceutical Policy. May 24, 2023

Medicare, Commercial Policy Type: Step Therapy

High Importance Update

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

This is a step therapy policy about Simbrinza (brinzolamide/brimonidine ophthalmic suspension).

Criteria #1 Previous treatment with dorzolamide AND brimonidine.

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092986cd2c94>

Humana: Oxervate™ (cenegermin) ophthalmic solution Pharmacy Coverage Policy. May 24, 2023

Medicare, Commercial Policy Type: Prior Authorization

High Importance Update

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

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092986cd2c80>

United Health Care Community Plan of Mississippi Brow Ptosis and Eyelid Repair (for Mississippi Only) Policy

Number: CS008MS.V. United Health Care Community Plan of Mississippi. Effective Date: July 1, 2023

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/comm-plan/ms/brow-ptosis-repair-ms-cs-07012023.pdf>

Wellcare Flex Card Benefit. May 26, 2023

“The Wellcare Flex Card Visa is a prepaid debit card that members can use to pay for any dental, vision or hearing, and in some cases, utility, services beyond plan benefits. The card can be used to cover things like dentures, sunglasses, extra hearing support devices or other qualifying costs that go beyond the member’s plan benefits. Please note that the Flex Card does not cover over the counter or grocery expenses.

The member’s plan determines the annual dollar amount on the Flex Card. The member will need to reference their Explanation of Coverage (EOC) to see the full breakdown of benefits. Members can log in to their Flex Card Member Portal to find plan allowance, balance, and details.

For more information on the Wellcare Flex Card Benefit please use this link <https://www.wellcare.com/flex>”

<https://www.wellcare.com/flex>