

## AUGUST 2023 THIRD PARTY NOTICES OF SIGNIFICANCE

### MISSISSIPPI DEPARTMENT OF MEDICAID, GAINWELL, AND MANAGED MEDICAID

#### **Centralized Credentialing for MSCAN/ MSCHIP. Mississippi Department of Medicaid Bulletin. July 2023**

“[Since October 1, 2022,] 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. ...

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 credentialing 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 to MESA and a link will be available in the portal to start the process. ...

Individual providers with multiple provider IDs sharing the same NPI and taxonomy 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. ... Providers can refer to DOM’s website where we are posting the Provider Six-Month Recredentialing Due List at <https://medicaid.ms.gov/>. 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.”

<https://medicaid.ms.gov/wp-content/uploads/2023/08/July-2023-Provider-Bulletin.pdf>

#### **DOM Resumes Provider Maintenance Operations (Licensure Review). Mississippi Department of Medicaid Bulletin. July 2023**

“...the Mississippi Division of Medicaid (DOM) has resumed its regular provider maintenance operation of monthly licensure review that was suspended in September 2022 for the implementation of MESA and transfer of our fiscal agent operations from Conduent to Gainwell Technologies. DOM will be updating provider records for both our fee-for-service/MississippiCAN providers as well as our CHIP providers. Providers can submit their licensure information to the Provider Enrollment Department of Gainwell Technologies via secure correspondence in the MESA Provider Portal, fax, or mail. The following information is provided: MESA Provider Portal: <https://medicaid.ms.gov/medicaid-portal-for-providers>”

<https://medicaid.ms.gov/wp-content/uploads/2023/08/July-2023-Provider-Bulletin.pdf>

#### **Mississippi Medicaid: Updates to MESA Portal for Providers. Late Breaking News. August 22, 2023**

“Mississippi Medicaid’s web portal for providers had been modified with the following improvements to make information easier to locate.

##### **Eligibility Verification Request:**

- The “Eligibility Verification Request” section was modified to allow the users to run a search for a span of 3 years. The system now allows running a search for eligibility up to 3 years in the past. Note: The system currently allows searching for eligibility up to 4 months in the future.
- The “Eligibility Verification Request” section was modified to rename the fields “Effective From” and “Effective To” to “Begin Date” and “End Date.”

- The Eligibility Verification Response section was modified to display the Aid Categories for the primary plan active during the search period.
- The Eligibility Verification Response section was modified to return the member's primary aid category's eligibility begin date and end date for the "Effective Date" and "End Date" fields. Member's add date of eligibility and the last date of update for the aid category are being displayed.
- The Eligibility Verification Inquiry Response Section was modified to display members' Hospital Presumptive Eligibility (HPE) along with the Effective Date, End Date, Add Date, and Last Update Date, if applicable. This section will not be displayed if there is no HPE data on the Member's file.

### **Coverage Details Page:**

- The "Limit Details" section on the "Coverage Details" page has a new field for "Service Date" input to display the relevant service limits.
- The "Lock-In Details" section on the Coverage Details page was modified to display the Lock-in plan start and end dates for the Effective and End Dates if the member has Lock-In coverage for the eligibility verification search duration.
- The "Lock-In Details" section on the Coverage Details page was modified to display "None" if the member does not have Lock-In coverage for the eligibility verification search duration.
- The "Managed Care Assignment Details" section on the Coverage Details page was modified to display the member's PCP's name and telephone number if the member is enrolled in a Managed Care plan for the eligibility verification search duration. The "Primary Care Provider" and "Provider Phone" are left blank if PCP is not selected by the member enrolled in a Managed Care plan for the eligibility verification search duration. ...
- The "Managed Care Assignment Details" section on the Coverage Details page was modified to display the member's active enrollment begin and end date along with the CCO of participation if the member is enrolled in a Managed Care plan for the eligibility verification search duration. Earlier, the Portal displayed the dates the eligibility verification search was being run for.
- The "Managed Care Assignment Details" section on the Coverage Details page was modified to display "None" if the member is NOT enrolled in a managed care plan for the eligibility verification search duration.

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>."

### **Mississippi Medicaid: Verification of Provider Licenses for Mississippi Medicaid. Late Breaking News. August 30, 2023**

"Under the guidelines of 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) will be actively updating the licensure records of both fee-for-service/MississippiCAN providers and CHIP providers. As a part of this endeavor, providers whose licenses have expired or are expiring will be notified via official correspondence from Gainwell Technologies. We also encourage providers to consult DOM's official website, where the Provider Six-Month License Due List is available at <https://medicaid.ms.gov/>. This list will be refreshed monthly to ensure the latest information is accessible. It is imperative for providers to promptly provide their updated licensure information to Medicaid, as failure to do so will result in the closure of their Medicaid provider number.

Complying with the provisions outlined in the Mississippi Administrative Code Part 200, Chapter 4, Rule 4.5 (B) (C), DOM will reinstate closed provider numbers due to license expiration, retroactive to the date of license renewal, provided the closure duration is under one (1) year. For this to happen, the provider must furnish a current license copy and rectify any changed or inaccurate information. If a

Medicaid provider number has been closed due to license expiration for a period exceeding one (1) year, re-enrollment as a Medicaid provider will be necessary.

To facilitate the submission of licensure information, Gainwell Technologies' Provider Enrollment Department offers multiple secure channels, including the MESA Provider Portal, fax, or mail. Here are the details for each method:

MESA Provider Portal: <https://medicaid.ms.gov/mesa-portal-for-providers>

Provider Services Fax Number: (866) 644-6148

Attention: Provider Enrollment

Provider Services Mailing Address:

Provider Enrollment/MississippiCAN/MSCHIP

PO Box 23078

Jackson, MS 39225"

### **Mississippi Medicaid: Enhancement of Timely Filing Process: Changes to MESA Edit 512 (EOB 0841). Late Breaking News. August 31, 2023**

"We are pleased to inform you about the ongoing collaborative efforts between the Mississippi Division of Medicaid (DOM) and Gainwell Technologies aimed at refining our timely filing procedures. Commencing from the week ending September 1, 2023, notable improvements will be introduced to the MESA Portal for Providers. This enhancement pertains to fee for service (FFS) claims processed and finalized during that week's financial run, specifically those flagged with MESA Edit 512 / EOB 0841 – denoting cases where the Timely Filing Deadline was Exceeded. It's important to note that these modifications will apply exclusively to straight Medicaid medical claims, excluding both crossover claims and pharmacy related claims.

The system will actively search for any previously submitted paid or denied claim that meets the matching criteria for that claim. If a timely filed matching claim is found that was submitted within 365 days of the last submitted claim, the claim will be reprocessed and bypass the timely filing edit. The resubmitted claim will appear on your remittance advice (RA) with the first two digits of 80 and will finalize in that week's financial cycle.

Should you require any assistance or have inquiries, we encourage you to reach out to our Provider and Beneficiary Services Call Center at (800) 884-3222. Alternatively, you can leverage the Provider Field Representative list accessible on Medicaid's official website. This list includes essential contact information, such as email addresses and phone numbers for each designated representative. For quick access, you can refer to the resource document located at: <https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf>. "

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

### **Molina Healthcare: Dextenza (dexamethasone intracanalicular ophthalmic insert) - Medical Policy 405. April 13, 2023**

This policy, provided for your reference, outlines all criteria that must be met for Molina to cover Dextenza

Reviewed with change(s) to supporting information. No changes to criteria.

[https://www.molinahealthcare.com/~media/Molina/PublicWebsite/PDF/Common/April2023/Dextenza\\_dexamethasone-intracanalicular-insert\\_R.pdf](https://www.molinahealthcare.com/~media/Molina/PublicWebsite/PDF/Common/April2023/Dextenza_dexamethasone-intracanalicular-insert_R.pdf)

### **United Health Care - Physicians (PCP, Specialists, and Behavioral Health) Are Required to Provide 24 Hours a Day, Seven Days a Week Coverage to Members. Mississippi Department of Medicaid Bulletin. July 2023**

"Acceptable after-hours messages or responses/coverage are:

- Primary Care Providers (PCPs) answering service will verify that it will contact the physician on-call for a patient's emergency.

- PCPs triage nurse will verify that he or she will speak with the patient for an emergency call, evaluate the nature of the emergency and contact the physician on-call, or direct the patient to a hospital emergency room.
- PCP can be reached when called directly.
- PCP's office phone message directs the patient to call a specific telephone number to reach the PCP's answering service, who will then contact the physician on-call for the emergency.
- PCP's office answering machine directs the patient to call a specific telephone number to reach a hospital switchboard and/or hospital emergency room that will reach the physician on-call for emergencies.

**Unacceptable after-hours messages or responses/coverage are:**

- PCP's answering machine directs the patient to proceed to the nearest hospital emergency room.
- PCP's office telephone number rings without an answer"

<https://medicaid.ms.gov/wp-content/uploads/2023/08/July-2023-Provider-Bulletin.pdf>

**We Speak Every Language. Magnolia Health. August 11, 2023**

"If your patient is a Magnolia Health member and needs an interpreter, we will provide one for free - 24 hours a day, 7 days a week.

To request an on-demand telephonic interpreter, please call 1-866-912-6285 and provide your patient's Magnolia ID number.

Using the speakerphone function is recommended for communication efficiency between you, your patient, and the interpreter.

Thank you for ensuring our members - your patients- can understand the healthcare they are receiving."

**Language Identification Tool**

I Speak\* charts like this help people who do not understand English to identify their language.

Patient points to a language and an interpreter is called

Magnolia provides interpretation for all members in their preferred language at no charge

Call Provider Services at 1-866-912-6285 to be connected with an interpreter.

Use the speakerphone function so the interpreter can speak directly to the member in your office."

You can find an "I Speak" Language Identification Tool [here](#).

**Magnolia Health Appointment and Access Requirements. August 11, 2023**

**See link for appointment timeframes**

"In addition to the ... appointment timeframes, providers are contractually required to ensure that provider coverage is available for members 24 hours a day, seven days a week. In addition, providers must maintain a 24-hour answering service and ensure that each primary care physician (PCP) provides a 24-hour answering arrangement, including a 24-hour on-call PCP arrangement for all members. An answering machine doesn't meet the requirements for a 24-hour answering service arrangement. Hospital emergency rooms or urgent care centers aren't substitutes for covering providers.

**After-Hour PCP care standard are:**

Magnolia's PCPs and specialty providers are required to maintain sufficient access to facilities and personnel to ensure that covered services are accessible to members twenty-four (24) hours a day, three hundred sixty-five (365) days a year. During after hours, a provider must have arrangements for:

Access to a covering provider

An answering service

A triage service

A voice message that provides a phone number for after-hours assistance

We routinely monitor for compliance with the above standards. Compliance monitoring includes, but is not limited to, conversations with your Provider Engagement Administrator, site visits and survey phone calls. Lack of compliance may lead to corrective actions, which may include corrective action plans or participation termination.”

<https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/AccessAvailblityStdGuidlin%20-%20508.pdf>

**Magnolia Health \*HEDIS® PROVIDER QUICK TIPS. August 11, 2023**

RHW: Please note the 92002, 92012, 92004 and 92014 codes in the list of wellness codes

Annual Wellness Visit: Members that had a wellness visit with a PCP or OB/GYN during the measurement year.

**Tips for Rate Improvement:**

- Review and close any open care gaps during the wellness-visit.
- Schedule next wellness-visit prior to member leaving the office.
- Send appointment reminders.
- Reschedule appointments for members who missed a visit.
- Ensure the medical record includes the date of service for all required documentation.
- Complete and accurate billing codes.
- Ensure claims and encounters are filed timely.

**Coding Tips for 3-20 years of age:**

CPT	HCPCS	ICD-10
99381-99385, 99391-99395, 99461	G0438, G0439, S0302, S0610, S0612, S0613	Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

**Coding Tips for 20 years of age and older:**

CPT	HCPCS	ICD-10
92002, 92004, 92012, 92014, 98966 - 98972, 99201 - 99205, 99211 - 99215, 99241 - 99245, 99304 - 99310, 99315, 99316, 99318, 99324 - 99328, 99334 - 99337, 99341 - 99345, 99347 - 99350, 99381 - 99387, 99391 - 99397, 99401 - 99404, 99411, 99412, 99421-99423, 99429, 99441 - 99443, 99444, 99457, 99461, 99483	G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2061, G2062, G2063, S0620, S0621, T1015	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

## CMS, NOVITAS SOLUTIONS, RAILROAD MEDICARE

### **Your Patient’s Medicare Beneficiary Identifier (MBI) May Change. CMS. August 3, 2023**

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

Ask your patient for their new Medicare card if you get “invalid member ID” when [checking Medicare eligibility](#). Access your [Medicare Administrative Contractor’s secure internet portal](#) to use the MBI look-up tool if your patient didn’t get a new Medicare card yet.”

<https://www.cms.gov/medicare/new-medicare-card/providers/providers-and-office-managers>

### **Claims Receiving Smart Edit Messages in Error. Novitasphere. August 14, 2023**

Due to an internal issue, all Jurisdiction L (JL) and Jurisdiction H (JH) claims submitted from 9:00pm ET on 8/11/2023, until 12:00am, 8/12/2023, received the below Smart Edit error message in error.

STC\*A3:23:41\*20230812\*U\*65\*\*\*\*\*SMARTEDIT IJ000453 UNABLE TO GET MANAGED CONNECTION FOR JAVAIBOSS/APOLLO-DATASOURCE~

For claims that received this error message, we ask that you please resubmit these claims/files. We apologize for the inconvenience.

#### Help Desk

1-855-880-8424

Monday-Friday 8 a.m.-5 p.m. ET

#### Reference

[Part A User Manual](#)

[Part B User Manual](#)

#### Quick Links

[Access Novitasphere](#)

[Access IDM](#)

### **Now Available: 2022 MIPS Performance Feedback, 2022 MIPS Final Score, and 2024 MIPS Payment Adjustment Information. CMS Quality Payment Program. August 10, 2023**

“The Centers for Medicare & Medicare Services (CMS) has released Merit-based Incentive Payment System (MIPS) performance feedback and final scores for the 2022 performance year and associated MIPS payment adjustment information for the 2024 payment year.

You can [view your 2022 MIPS performance feedback](#), including your final score and 2024 payment adjustment on the [Quality Payment Program \(QPP\) website](#).

[Sign in](#) using your Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) system credentials; these are the same credentials that allowed you to submit your 2022 MIPS data. Click “View Feedback” on the home page.

Select your organization (Practice, Alternative Payment Model (APM) Entity, Virtual Group).

Practice representatives can access both individual and group feedback.

If you don’t have a HARP account or QPP role, please refer to the Register for a HARP Account (re: HARP account) and Connect to an Organization (re: QPP role) documents in the [QPP Access User Guide \(ZIP, 4MB\)](#) and start the process now.

#### **Performance Feedback Resources Available**

To learn more about the information in your performance feedback, review the following 2022 MIPS Performance Feedback:

[2022 MIPS Performance Feedback FAQs \(PDF, 3MB\)](#) – Highlights what performance feedback is, who receives the feedback, and how to access it on the Quality Payment Program website.

[2022 MIPS Performance Feedback Patient-Level Data Reports Supplement \(PDF, 845KB\)](#) – Reviews the data included, and answers questions about the downloadable patient-level reports included in performance feedback.

[2022 Quality Performance Period Benchmarks \(ZIP, 237KB\)](#) – Identifies the performance period benchmark results (as available) for quality measures without a historical benchmark and provides general information about performance period benchmarks.

[2022 Cost Performance Period Benchmarks \(ZIP, 264KB\)](#) – Identifies the performance period benchmark results (as available) for cost measures.

[2024 MIPS Payment Year Payment Adjustment User Guide \(PDF, 710KB\)](#) – Reviews information about the calculation and application of MIPS payment adjustments, and answers frequently asked questions.

### **COVID-19 Flexibilities**

CMS continued to allow individuals, groups, virtual groups and APM Entities to request performance category reweighting through the [MIPS Extreme and Uncontrollable Circumstance \(EUC\) Exception Application](#). Data submission wasn't required for the performance categories approved for reweighting.

### **New Place of Service Code 27 – Outreach Site/Street. CMS. August 24, 2023**

“The Place of Service Committee recently created new place of service code 27, Outreach Site/Street, which will be effective October 1, 2023. At this time, Medicare won't use this code in claims processing. If you submit a claim with this code, we'll return it to you. See the instruction to your [Medicare Administrative Contractor](#) for more information.”

### **Medicare Provider Enrollment - Revised. CMS. August 17, 2023**

- Added PECOS 2.0 information and resources
- Clarified that Medicare Administrative Contractors pre-screen enrollment applications for completeness
- Clarified reporting partnership interest or ownership under 1 tax identification number, when applicable
- Added examples of information you should have available when applying for Medicare enrollment
- Added information about checking your PECOS enrollment application status
- Added examples of when a person or entity needs to create a new enrollment
- Clarified the time frame for getting a revalidation notice
- Added common terms: director, managing organization, officer

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html>

## **OTHER**

### **US Oversight Committee To Investigate FTC's Regulation Of Vision Insurance. AOA First Look. August 10, 2023**

According to [Reuters](#) (8/8, Singh), on Aug. 8, “the U.S. House of Representatives Oversight Committee said...it has opened a probe into the Federal Trade Commission's (FTC) regulation of vision care over concerns about concentration in the insurance market.” US Rep. James Comer (R-KY) stated, “The vision insurance market is structured to place only a handful of companies in charge of the vast majority of vision insurance plans for Americans, raising concerns about effects on consumers, including potentially higher costs.” Currently, “vision insurance is offered by specialty insurance companies in the United States, and the largest company, VSP Vision Care (VSP), covers over two-thirds of U.S. enrollees who have vision-only insurance plans, Comer wrote” in a [letter](#) (PDF) to FTC Chair Lina Khan.

**Aetna: Dry Eye Diagnosis and Treatment - Medical Policy 0457. July 11, 2023**

Reviewed with changes to criteria, supplementary information, and formatting.  
Updated experimental and investigational criteria (see policy for complete changes);  
Updated supporting and administrative information;  
Revised policy with minor formatting changes.

[https://www.aetna.com/cpb/medical/data/400\\_499/0457.html](https://www.aetna.com/cpb/medical/data/400_499/0457.html)

**Aetna: Graves' Ophthalmopathy Treatments - Medical Policy 0419. August 10, 2023**

“Reviewed with changes to coding and formatting. Added the following HCPCS code: Q5131;  
No changes to criteria; Revised policy with minor formatting changes.

[https://www.aetna.com/cpb/medical/data/400\\_499/0419.html](https://www.aetna.com/cpb/medical/data/400_499/0419.html)

**Aetna: Vision Therapy - Medical Policy 0489. July 14, 2023**

“Reviewed with changes to criteria, coding, supplementary information, and formatting.  
Updated experimental and investigational criteria (see policy for complete changes);  
Updated ICD-10 diagnosis codes; Updated supporting and administrative information;  
Revised policy with minor formatting changes.”

[https://www.aetna.com/cpb/medical/data/400\\_499/0489.html](https://www.aetna.com/cpb/medical/data/400_499/0489.html)

**CVS Caremark: Retinal Disorders/Ocular Specialty (PR) - Enrollment Form. Updated August 21, 2023.**

Issued a new version of the form. Prior approval for the coverage of Durysta, Iluvien and Susvimo

[https://www.cvsspecialty.com/content/dam/enterprise/specialty/enrollment\\_forms/hi-pr/PR\\_Retinal\\_Disorders\\_Ocular\\_Specialty.pdf](https://www.cvsspecialty.com/content/dam/enterprise/specialty/enrollment_forms/hi-pr/PR_Retinal_Disorders_Ocular_Specialty.pdf)

**BCBS Federal Employee Plan: Eyelid Thermal Pulsation for the Treatment of Dry Eye Syndrome - Medical Policy 9.03.29. July 1, 2023**

“Reviewed with minor formatting changes. No changes to criteria.

Eyelid thermal pulsation therapy to treat dry eye syndrome is considered investigational.”

<https://www.fepblue.org/-/media/PDFs/Medical%20Policies/June-2023/Med%20Remove-Replace/90329%20Eyelid%20Thermal%20Pulsation.pdf>

**BCBS Federal Employee Plan: Ophthalmologic Techniques That Evaluate the Posterior Segment for Glaucoma - Medical Policy 9.03.06. July 1, 2023**

“Reviewed with change(s) to supporting information. No changes to criteria.

The measurement of ocular blood flow, pulsatile ocular blood flow, or blood flow velocity is considered investigational in the diagnosis and follow-up of individuals with glaucoma.”

<https://www.fepblue.org/-/media/PDFs/Medical%20Policies/June-2023/Med%20Remove-Replace/90306%20Ophthalmologic%20Techniques.pdf>

**Cigna Healthcare Removes 25 Percent of Medical Services From Prior Authorization, Simplifying the Care Experience for Customers and Clinicians. August 24, 2023**

“Cigna Healthcare, the health benefits provider of The Cigna Group (NYSE: CI), announced the removal of nearly 25 percent of medical services from prior authorization (or precertification) requirements. With the removal of these more than 600 additional codes, the company has now removed prior authorization on more than 1,100 medical services since 2020, with the goal of simplifying the health care experience for both customers and clinicians.”

<https://newsroom.cigna.com/2023-08-24-Cigna-Healthcare-Removes-25-Percent-of-Medical-Services-From-Prior-Authorization,-Simplifying-the-Care-Experience-for-Customers-and-Clinicians>

**Humana: Alphagan-P (Commercial) - Pharmaceutical Policy, Step Therapy (ST) Criteria. July 26, 2023**

“Reviewed with change(s) to criteria, supplementary information, and formatting.  
Removed criteria regarding approval forms for members who do not meet listed criteria;  
Removed coverage limitations; Updated supporting and administrative information;  
Updated policy template.”

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092987417bbc>

**Humana: Cosopt (Medicare, Commercial) - Pharmaceutical Policy, Step Therapy (ST) Criteria. July 16, 2023**

Reviewed with change(s) to criteria, supplementary information, and formatting.  
Removed coverage criteria regarding approval forms for members who do not meet criteria listed in policy; Removed coverage limitations;  
Updated supporting and administrative information; Updated policy template.

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=09000929874cd06a>

**Humana: Rocklatan (Commercial) - Pharmaceutical Policy. July 26, 2023**

“Reviewed with change(s) to criteria, supplementary information, and formatting.  
Removed criteria regarding approval forms for members who do not meet listed criteria;  
Removed coverage limitations; Updated supporting and administrative information;  
Updated policy template.”

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092987417bba>

**Molina Healthcare: Tepezza (Marketplace) (Individual) - Pharmaceutical Policy C18462-A. August 23, 2023**

“Reviewed with changes to criteria, supplementary information, and formatting.  
Removed thyroid eye disease (TED) baseline clinical activity score criterion(see policy for complete changes);  
Removed TED active phase documentation criteria; Updated TED documented diagnosis criterion;  
Updated TED proptosis documentation criterion; Updated supporting and administrative information;  
Revised policy with minor formatting changes.”

<https://www.molinamarketplace.com/~media/Molina/PublicWebsite/PDF/Providers/common/pa-criteria/Tepezza-teprotumumab-trbw-C18462-A-508c.pdf>

**UHC Community Plan: Glaucoma Surgical Treatments (Medicaid) - Medical Policy CS050.U. Effective October 1, 2023**

“Reviewed with changes to coding and supplementary information.  
Removed codes 66184 and 66185;  
Revised criteria language with no changes to intent;  
Updated supporting information.”

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/comm-plan/glaucoma-surgical-treatments-cs-10012023.pdf>

**United Healthcare: Coverage Summary Updates (Medicare Advantage) - News & Announcements. August 1, 2023**

“New bulletin. Including Glaucoma Surgical Treatments and TeleMedicine/Telehealth Policies  
Payer has announced various criteria and supporting information changes. Please refer to the attached bulletin for complete information.”

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-coverage-sum/medicare-advantage-coverage-summary-update-bulletin-august-2023.pdf>

**Glaucoma Surgical Treatments:**

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-coverage-sum/glaucoma-surgical-treatments.pdf>

## **UnitedHealthcare Medicare Advantage Reimbursement Policy Update Bulletin: August 2023**

RHW: This policy seems to indicate that in order to provide glasses after cataract surgery for UHC Medicare Advantage plan patients, the provider must be a DME provider.

New		
Policy Title	Effective Date	Policy Summary
Eligible Ordering and Referring Provider NPI CMS Requirement	November 1, 2023	<ul style="list-style-type: none"><li>• Effective with date of service September 1, 2023, UnitedHealthcare Medicare Advantage will align with the Centers for Medicare and Medicaid Services (CMS) requirement that a legally eligible ordering/referring provider be identified on all claims all claims billed by Clinical Laboratories, Imaging Centers, DME Suppliers and Home Health Agencies. Claims will be denied when the CMS Ordering/Referring Provider eligibility criteria are not met.</li><li>• The new claim edits will determine if the Ordering/Referring Provider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries.</li><li>• The Ordering &amp; Certifying Files lists all providers who are currently eligible to order and certify. These files are only available on the CMS Data website.</li></ul>

Published reimbursement policies are intended to ensure reimbursement based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-reimbursement/rpub/UHC-MEDADV-RPUB-AUG-2023.pdf>

## **United Healthcare: Ocular Telescope (Medicare Advantage) - Medical Policy MPG 222.09. Approved July 12, 2023**

No changes to criteria.

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-guidelines/o/ocular-telescope.pdf>