

June 2025 Third Party Changes of Significance

MISSISSIPPI MEDICAID-CHIPS

Magnolia Health Serving Mississippi CHIP Members Beginning July 1, 2025. Centene Vision-Magnolia Health Bulletin. June 5, 2025

“Involve Vision, doing business as Centene Vision Services, will administer vision benefits to the Magnolia Health Mississippi CHIP population beginning July 1, 2025.

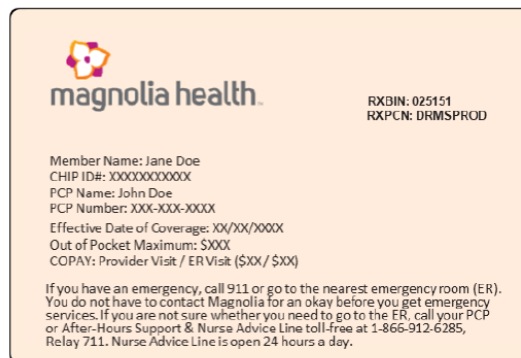
Provider materials, including the Centene Vision provider manual and information on vision benefit details, claims submissions, and key contact information, will be posted on the provider portal at centenevision.com/login by July 1, 2025.

Please be sure to verify member eligibility and benefits prior to rendering services by logging onto the portal or calling Centene Vision Provider Customer Service at the number listed below.

As always, thank you for being our partner in serving Magnolia Health members. If you have questions, please call our Customer Service team at **888-241-0663**.”

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|---|--|
| Centene Vision Paper Claims | Centene Vision Services P.O. Box 7548 Rocky Mount, NC 27804 |
| Centene Vision Electronic Claims | EDI # 56190 |
| Centene Vision Customer Service | 888-241-0663 |

Member ID Card Example



Attention Durable Medical Equipment Providers Receiving Medicare Part B Claim Denials with Edit/EOB 2502. Late Breaking News. June 25, 2025

“The Division of Medicaid and Gainwell recently updated Medicare Part B system edit 2502 which impacts Durable Medical Equipment (DME) providers. Refer to the previous Late Breaking News article posted on 2/15/2024, (pictured below) clarifying the process for submitting claims to Medicaid for full-benefit dual eligible members with Medicare when Medicare denied services billed. Claims that fit this scenario must be submitted to Medicaid by Provider Portal, 837 EDI transaction, or paper, as a Medicaid Only claim with the Medicare Explanation of Medicare Benefits (EOMB) attached showing Medicare denied the services and the denial reason.

The 837 EDI transaction claims will suspend up to 21 days awaiting receipt of attachment. Claims and EOMB attachments will be reviewed to validate the Medicare denial reason(s). If Medicare denied for “Not Medically Necessary,” the claim will be denied by Medicaid. Claims will process according to all Medicaid policies and billing rules for any other denial reasons.

For Medicare Crossover claims submitted via the EDI X12 (electronic submission), the provider must create a unique Attachment Control Number (ACN) for each claim. The ACN must be entered in the 'PWK06' segment of the transaction. Also, a value of 'BM' (for By Mail) must be entered in the 'PWK02' segment. A Claim Attachment Form must accompany each EOMB and must identify the Provider NPI, Attachment Control Number (ACN) as it was entered in the PWK segment, Claim ID/ICN and Member ID Number. The Claim Attachment Form is located at: [https://medicaid.ms.gov/resources/forms/ ...](https://medicaid.ms.gov/resources/forms/)

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

UnitedHealthcare Community Plan of Mississippi Market Departure. Late Breaking News. June 25, 2025

“The following is an announcement to the provider community from UnitedHealthcare Community Plan.

We regret to inform you that UnitedHealthcare Community Plan (“UnitedHealthcare”) will not be a Mississippi Health Care Programs option for members effective July 1, 2025. This includes the following health plans:

- Coordinated Access Network Program (MSCAN)
- Children’s Health Insurance Program (CHIP)

Members have been notified

We remain committed to our members and to you as one of our participating care providers. UnitedHealthcare members impacted by this change were notified and assigned a new health plan by the Mississippi Division of Medicaid to ensure a smooth transition of care.

Who’s not affected

If you’re a contracted care provider for UnitedHealthcare for Commercial HMO, PPO or POS and Medicare Advantage (including DSNP), this change **does not** affect members under those plans. However, UnitedHealthcare will no longer serve members under Mississippi CAN and CHIP Programs effective **July 1, 2025**.

Member care

We’ll continue to provide member care until June 30, 2025. Please use the following guidelines during this transition:

Eligibility and benefits – Continue to verify member eligibility every time a member seeks care.

Claims submission – Continue to submit claims for eligible members with dates of service up to and including **June 30, 2025**. UnitedHealthcare will remain responsible for all medically necessary services rendered to our members through **June 30, 2025**, at 11:59 p.m. Effective July 1, 2025, the new health plan will be responsible for the members’ care, claims and authorizations unless a member is at an inpatient facility and is expected to remain past **June 30, 2025**.

Note: Please ensure that all claims are submitted for payment within **180 days** of the date of service or date of discharge.

Member questions – Members can still reach out to us using the phone number on the back of their ID card. Our member services team will continue to be available to assist with their questions.

Continuity of care – Please call the member’s new managed care organization (MCO) beginning **July 1, 2025**, to better understand their continuity of care procedures. UnitedHealthcare coverage for all members ends **June 30, 2025**, unless a member is at an inpatient facility and is expected to remain past **June 30, 2025**. In those cases, UnitedHealthcare will continue to administer the inpatient members’ benefits through discharge.

Disputes and appeals – Our care provider dispute and appeals process and member appeals and grievances process will remain the same.

• **UnitedHealthcare care providers:** Please consult your contract and the UnitedHealthcare Community Plan of Mississippi Care Provider Manual at **UHCprovider.com** > Coverage and payments > Administrative guides and manuals > Community Plan Care Provider Manuals for Medicaid Plans by State for information on provider and member appeals and grievances

We’re here to help

To help make this transition easier for you, UnitedHealthcare remains committed to providing support for our care provider network after the contract end date of **June 30, 2025**.

• **UnitedHealthcare care providers:** You can continue to access **UHCprovider.com** for information and support

Thank you for your partnership and for your care to our UnitedHealthcare Community Plan of Mississippi members.

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

Processing Prior Authorizations and Appeals during the transition of Managed Care Organizations. June 18, 2025

“Beginning July 1, 2025, United Healthcare (UHC) will no longer serve as a Managed Care Organization (MCO) for Mississippi Division of Medicaid (DOM). All DOM beneficiaries enrolled with UHC will be disenrolled on 6/30/2025 and will be transferred to a new MCO or to Fee for Service, depending on the member’s choice. Please check MESA to verify all eligibility.

Please see significant dates regarding Prior Authorization and MCO Appeals

Important Notice for Prior Authorizations

All prior authorization requests for dates of service starting 7/1/2025 should be directed to the beneficiary’s assigned MCO. UHC will not be able to provide a review or decision on these services.

Important Notice for Appeals – Action Required

If you are submitting an appeal for a service that you have not completed, please be aware of the following deadlines to ensure the beneficiary’s appeal is reviewed while still eligible with UHC:

- Standard Pre-Service Appeals must be received no later than June 17, 2025
- Expedited Pre-Service Appeals must be received no later than June 27, 2025

Being attentive to these dates when submitting an appeal will ensure timely review and continued eligibility. After these dates, all Pre-Service Appeals should be filed directly with the newly assigned MCO. We’re committed to working together to make this change as smooth as possible.”

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

License Renewal with the Division of Medicaid. Magnolia Health Weekly News and Updates. June 27, 2025

“Incompliance with 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) is required to maintain up-to-date licensure documentation for all enrolled providers, including those participating in fee-for-service, MississippiCAN and CHIP programs.

To prevent deactivation of Medicaid provider numbers and interruption in claims payments, providers must submit current licensure information promptly.

With a high volume of licenses set to expire on June 30, 2025, it is strongly recommended that providers submit renewed licenses as soon as possible to ensure sufficient processing time and avoid any potential disruptions in payment.

Who Is Affected?

Although not an exhaustive list, providers holding licenses issued by the following Mississippi state boards may be affected:

- Mississippi State Board of Medical Licensure
- Mississippi State Board of Physical Therapy
- Mississippi Board of Chiropractic Examiners
- Mississippi Board of Psychology
- Mississippi State Department of Health

License Expiration Notifications

Providers whose licenses are expiring will receive letters of notification by mail from Gainwell Technologies. As noted in the December 30, 2024, Late Breaking News article, the notification will also be available for viewing in the provider portal.

To stay informed, DOM encourages providers to check the Provider Six-Month License Due List, available and updated monthly on the DOM website: [View the Provider License Due List](#)

How to Submit Updated Licenses

Licenses should be submitted electronically via the MESA Provider Portal: [Access the MESA Provider Portal](#) (Use the Secure Correspondence feature. A tracking number will be provided upon submission.)

For any assistance required between 8 a.m. and 5 p.m. CST, providers can contact the Provider and Beneficiary Services Call Center at (800) 884-3222.

Provider Services has a NEW Phone Number. Magnolia Health Weekly News and Updates. June 27, 2025

“Please note effective July 1, 2025, Provider Services can be reached at our **new** number **1-877-236-0751** for MSCAN and CHIP.”

Checkout these New Secure Provider Portal Features. Magnolia Health Weekly News and Updates. June 27, 2025

“We are excited to share that new features have been added to the Magnolia Secure Provider Portal. See the list of new portal features that have been added.

- Access to a copy of the Provider Manual
- Access to newsletters, updates, and Provider Notices
- Access to a searchable Provider Directory
- Submit claim appeals
- Submit grievance and appeals
- Submit referrals to Care Management
- Z-Code Dashboard – Additional Learning: Visit CMS.GOV [USING Z CODES](#)”

Clean Claim Reviews. Magnolia Health Weekly News and Updates. June 27, 2025

“Frequently Asked Questions

Magnolia Health MSCAN has partnered with 6Degrees Health to begin performing clean claim reviews to ensure appropriate billing effective **July 28, 2025**. All reviews will be performed by registered nurses with extensive clinical experience, and billing is evaluated against CMS and industry standards to ensure the claim has been billed accurately before payment.

What do I do if I did not receive the full contracted payment for my claim?

Please contact 6 Degrees Health at the number below. However, you received an amount lower than expected because a clean claim review was performed.

Reconsiderations, Disputes and Appeals

Where do I submit documentation if I do not agree with the Clean Claim review findings?

You may contact 6 Degrees Health at the number below, or you can submit additional documentation for reconsideration, or you can exercise your appeal rights. **ALL** inquiries should be submitted to 6 Degrees Health:

Mail: PO Box 5967, Fredericksburg, VA 22403

Direct: 503.640.9933, Option 3

Email: cleanclaimsappeals@6degreeshealth.com

Fax: 888.507.0489

What are EX CODES?

Certain EX CODES mean a Clean Claim review was completed. If EX CODES n0, n9, m0, m3, m4, or m5 are present on the EOP, it means that 6 Degrees Health conducted a review.

What kind of information can we send to make items payable that were originally denied?

When submitting a formal appeal, you can send medical records or other documentation supporting your billing practices, such as billing policies to:

Mail: PO Box 5967, Fredericksburg, VA 22403

Direct: 503.640.9933

Email: cleanclaimsappeals@6degreeshealth.com

NOTICE TO PROVIDERS. Magnolia Health Weekly News and Updates. June 27, 2025

“Dear Provider,

You may have recently received a letter from Magnolia Health Plan with information regarding an upcoming claims recoupment for project numbers 574360310 and/or 577431021 related to members

who were not eligible at the date of the service. **We plan to pause this recoupment and work with the Division of Medicaid to coordinate the recoupment and potential repayment of these claims under another payor.**

There is **no need** for providers to **appeal** these claim recoupments.

We will also be including more information in our weekly Provider email blasts, so please watch for upcoming information.

To sign up for Magnolia's email blast, visit our website

at www.magnoliahealthplan.com/providers/email-sign-up.html

If you have any questions, or need additional information regarding this issue, please contact your provider relations representative, or Provider Services at 866.912.6285."

<https://mailchi.mp/c2567f799c82/pooscgsvfh-42340?e=6d63e1c4a4>

CMS, NOVITAS, RAILROAD MEDICARE

CMS Alert: Medicare Fraud Scheme Involving Phishing Fax Requests. Medicaid Late Breaking News. June 24, 2025

"The Centers for Medicare & Medicaid Services (CMS) has identified a fraud scheme targeting Medicare providers and suppliers. Scammers are impersonating CMS and sending phishing fax requests for medical records and documentation, falsely claiming to be part of a Medicare audit.

Important: CMS doesn't initiate audits by requesting medical records via fax. Protect your information. If you receive a suspicious request, don't respond. If you think you got a fraudulent or questionable request, work with your [Medical Review Contractor](#) to confirm if it's real."

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

Submit Paperless eClaims Through eServices. Railroad Medicare-Palmetto GBA. March 28, 2025

"As an alternative to submitting electronic claims using the 837P transaction, Railroad Medicare providers can submit paperless Part B claims online through the Palmetto GBA secure portal, eServices. Please review and share this information with your staff."

<https://palmettogba.com/rr/did/bpdrzm8567#ls>

[MIPS] Initial 2023 Performance Year Quality Payment Program Participation and Performance Data Available. CMS Quality Program. June 5, 2025

"Today, the Centers for Medicare & Medicaid Services (CMS) released the first round of participation and performance data for the 2023 performance year of the Quality Payment Program (QPP), including both Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) participation.

The following resource is now available:

- The [2023 QPP Participation and Performance Results At-a-Glance \(PDF\)](#) provides a snapshot of aggregated data for key QPP program metrics, including a high-level overview of participation, scoring, and payment adjustment information.

The following resources will be available by July 2025:

- The 2023 QPP Experience Report will provide a more in-depth review of aggregated data on QPP program experience and review of program trends over time. It will include an expansive set of aggregated program metrics on participation, performance category scoring, final scores, and payment adjustments factors.
- The 2023 QPP Public Use File will provide clinician-level data at the Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) level regarding clinician eligibility, measure level scoring, performance category scoring, final scores, and payment adjustments factors.

Data Highlights

Highlights of the QPP Participation and Performance Results At-a-Glance include:

- The total number of MIPS eligible clinicians receiving a payment adjustment, including the number and percentage of non-reporting clinicians.
- The mean and median 2023 MIPS final scores, as well as the mean and median unweighted scores for each performance category.
- The maximum 2025 MIPS payment adjustment amount (paid to clinicians with a final score of 100 points).
- The total number of Qualifying APM Participants (QPs).

Additional Resources

To learn more about the 2023 QPP Participation and Performance Results At-A-Glance, you can review the following supporting documentation:

- [2023 Data Use Guide \(PDF\)](#)

You can also find all of the QPP Data Resources (including those from prior years) on the [Participation and Performance Data page](#) of the QPP website.”

Palmetto GBA Video Library Module. Railroad Medicare-Palmetto GBA. May 29, 2025

This module provides an interactive tour of the Palmetto GBA video library. For information on how to register and log into the video library, we encourage you to check our Webinars 101 module. Please review this information and share it with your staff. To view the Palmetto GBA Video Library Module, please select one of the following link:

- [Railroad Medicare](#)

<https://palmettogba.com/jjb/did/941reab8qf#ls>

eServices Data Availability. Railroad Medicare - Palmetto GBA. June 27, 2025

“This article provides the times different information is available within eServices for claims data, remittances, beneficiary information and financial data. Please share with appropriate staff.”

<https://palmettogba.com/jjb/did/9yqfxb5750#ls>

Jurisdictions J and M, Railroad Medicare for CERT: Lunch and Learn Webcast Focusing on Chronic Care Management Services Documentation Requirements: August 7, 2025. Railroad Medicare – Palmetto GBA. June 27, 2025

“Event Date: 08-07 1:00 PM EDT - 1:30 PM EDT

Register today to enjoy your lunch with Palmetto GBA Jurisdiction J, Jurisdiction M and Railroad Medicare for the second event of our two-part series where we will discuss the Comprehensive Error Rate Testing Contractor (CERT) and Chronic Care Management (CCM) services with a spotlight on documentation requirements. This session is designed to help you gain a better understanding of CERT, errors relating to chronic care management, present methods for preventing future occurrence and to provide you with guidelines and medical record documentation expectations. Following the content of this webcast, we will share resources related to our session and give you the opportunity to ask questions about the information covered in this event. Please plan to attend.”

<https://palmettogba.com/jmb/did/eve148fe37wylr0807>

OTHER

FTC Sends Warning Letters to Prescribers Regarding Possible Violations of the Contact Lens Rule. FTC Press Release. June 3, 2025

“The Federal Trade Commission sent letters to 37 eyeglass and contact lens vendors opens in a new tab or window warning them of possible violations of federal rules related to charging extra fees for releasing prescriptions to patients.”

https://www.ftc.gov/news-events/news/press-releases/2025/06/ftc-sends-warning-letters-prescribers-regarding-possible-violations-contact-lens-rule?utm_source=govdelivery

Supreme Court Issues Ruling on ACA's Preventive Care Mandate. Joyce Frieden. MedPage Today. June 27, 2025

"The Supreme Court on Friday preserved a key aspect of the Affordable Care Act's (ACA) preventive coverage mandate, handing a defeat to employers who don't want to be required to cover certain preventive care services.

In the 6-3 decision, [the Supreme Court ruled opens in a new tab or window](#) that the appointment of members to the U.S. Preventive Services Task Force (USPSTF) is constitutional. "Task force members are inferior officers whose appointment by the secretary of HHS is consistent with the Appointments Clause" of the Constitution, the court wrote in its summary, which was authored by Justice Brett Kavanaugh...."

https://www.medpagetoday.com/primarycare/preventivecare/116288?xid=NL_breakingnewsalert_2025-06-27&mh=d530d60d447e978281954fa4d597664f&zdee=gAAAAABm4wxixXOEzKiBSsb6aj8cJdpE5vzvovRUbe7ess78fc8PayW-dEI3Gmd2osS83XEjhAF171BN78ot0dDa5Z_klvMZ6rbftQIF164--yFYdhGUWGs%3D&utm_source=Sailthru&utm_medium=email&utm_campaign=BraidwoodAlert_062725&utm_term=NL_Daily_Breaking_News_Active

Medicare Advantage, Traditional Medicare Cost Gap Widening: Better Medicare Alliance. Becker's Payer Issues. Rylee Wilson. June 18, 2025

"The gap in out-of-pocket spending between Medicare Advantage and fee-for-service beneficiaries is widening, according to a report from the Better Medicare Alliance.

The pro-Medicare Advantage group, backed by major insurers, commissioned the analysis, which was conducted by ATI Advisory. The report, based on data from the Medicare Current Beneficiary Survey, and was published June 16.

Here are five findings to know:

1. In 2022, Medicare Advantage beneficiaries spent \$3,486 less out of pocket on healthcare costs than fee-for-service enrollees.
2. The average difference in spending between fee-for-service and MA enrollees grew by 37% from 2021 to 2022, or about \$945.
3. More than half of Medicare Advantage enrollees reported incomes less than half of the federal poverty level, compared to one in three FFS enrollees.
4. In 2022, 13% of MA enrollees reported a cost burden from healthcare expenses, compared to 20% of FFS beneficiaries.
5. Medicare Advantage and FFS beneficiaries reported similar levels of satisfaction with their access to and quality of care in 2022.

Read the full report [here](#).

https://www.beckerspayer.com/payer/medicare-advantage-traditional-medicare-cost-gap-widening-better-medicare-alliance/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J801653418J