September 2025 Third Party Changes of Significance

MISSISSIPPI MEDICAID

Rendering/Facility Provider Usage Change. LateBreaking News. September 9, 2025

"The Mississippi Division of Medicaid (DOM) will reprocess claims where the claim was not submitted with a rendering provider ID, or the rendering provider ID was invalid. The claims process used the following NPI matching for the NPI Crosswalk of Rendering providers.

1. One to One match using the NPI to the Billing Provider Group. If no match was found, then…
2. One to One match using the Providers listed in the Billing provider group and the Rendering Taxonomy. If no match, then…
3. One to One match using the Providers listed in the Billing provider group, Rendering Taxonomy and the Zip+4 from the Facility Provider, if Present on the claim. If No Facility Provider is submitted on the claim, then use the Zip+4 from the Billing Provider submitted Address. If no match, then…
4. The claim/detail(s) denied with provider billing edits.

Providers impacted by this Mass Adjustment (MA) should submit a corrected claim for payment. In the event that the corrected claim(s) deny for timely filing, providers are reminded that in accordance with Part 200, Rule 1.8(A)(2), providers may request an Administrative Review regarding claims within ninety (90) calendar days of the denial of a claim, when the Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired. Requests for an Administrative Review must include documentation that explains the facts that support the provider's position as to how the denied claim meets one (1) or more of the requirements in Miss. Admin. Code, Title 23, Part 200, Rule 1.8.A. and the reasons the provider believes he/she complied with Medicaid regulations, and other documentation as required or requested by DOM.

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/2025/04/Q2-2025-PROVIDER-FIELD-REPRESENTATIVES_Map-and-By-County.pdf.

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

Important Reminder: Timely Filing Review Requests. DOM Late Breaking News. September 23, 2025

"The Division of Medicaid (DOM) reminds providers that all **timely filing review requests submitted to DOM online, by mail, or by facsimile must include a formal letter.**

Your letter should:

- Describe the issues relevant to the timely filing denial.
- Provide justification for consideration during the review.

In addition, providers must submit all **supporting documentation** that substantiates the request. Please note that **failure to provide all required documentation may result in delays** to your review.

Administrative Code References

Providers should review the following sections of the Administrative Code for guidance:

Part 200, Rule 1.6: Timely Filing

- **Part 200, Rule 1.7:** Timely Processing of Claims
- **Part 200, Rule 1.8:** Administrative Review for Claims
- **Part 300, Chapter 4:** Claim Denials for Policy Regarding Administrative Reviews

The full Administrative Code can be accessed here: https://medicaid.ms.gov/providers/administrative-code/.

Please note that specific documentation requirements are detailed in **Part 200, Rule 1.8(B).**

Next Steps for Providers

When submitting a timely filing review request:

Include a formal letter with your request.

- Clearly explain the issues related to the timely filing denial.
- Provide justification for DOM to consider.

- Attach all supporting documentation.
- Reference the applicable Administrative Code rules to ensure compliance."

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

CMS, NOVITAS, RAILROAD MEDICARE

Update on Medicare Operations: Telehealth, Claims Processing, and Medicare Administrative Contractors Status During the Shutdown. CMS MLN Special Notice. October 1, 2025

"When certain legislative payment provisions ("extenders") are scheduled to expire, CMS directs all Medicare Administrative Contractors (MACs) to implement a temporary claims hold. This standard practice is typically up to 10 business days and ensures that Medicare payments are accurate and consistent with statutory requirements. The hold prevents the need for reprocessing large volumes of claims should Congress act after the statutory expiration date and should have a minimal impact on providers due to the 14-day payment floor. Providers may continue to submit claims during this period, but payment will not be released until the hold is lifted.

Absent Congressional action, beginning October 1, 2025, many of the statutory limitations that were in place for Medicare telehealth services prior to the COVID-19 Public Health Emergency will take effect again for services that are not behavioral and mental health services. These include prohibition of many services provided to beneficiaries in their homes and outside of rural areas and hospice recertifications that require a face-to-face encounter. In some cases, these restrictions can impact requirements for meeting continued eligibility for other Medicare benefits. In the absence of Congressional action, practitioners who choose to perform telehealth services that are not payable by Medicare on or after October 1, 2025, may want to evaluate providing beneficiaries with an Advance Beneficiary Notice of Noncoverage. Practitioners should monitor Congressional action and may choose to hold claims associated with telehealth services that are not payable by Medicare in the absence of Congressional action. Additionally, Medicare would not be able to pay some kinds of practitioners for telehealth services. For further information: https://www.cms.gov/medicare/coverage/telehealth.

CMS notes that the Bipartisan Budget Act of 2018 allows clinicians in applicable Medicare Shared Savings Program Accountable Care Organizations (ACOs) to provide and receive payment for covered telehealth services to certain Medicare beneficiaries without geographic restriction and in the beneficiary's home. There is no special application or approval process for applicable ACOs or their ACO participants or ACO providers/suppliers. Clinicians in applicable ACOs can provide these covered telehealth services and bill Medicare for the telehealth services that are permissible under Medicare rules during CY 2025, irrespective of further Congressional action. For more information: https://www.cms.gov/files/document/shared-savings-program-telehealth-fact-sheet.pdf.

MACs will continue to perform all functions related to Medicare Fee-for-Service claims processing and payment."

DME: Complying with Proof of Delivery Requirements. CMS MLN Matters. September 4, 2025

"The Comprehensive Error Rate Testing (CERT) Task Force identified missing or incomplete proof of delivery (POD) documents for DME claims. You're required to maintain POD documentation for 7 years from the date of service regardless of your delivery method.

Use the CERT DME POD Requirements (PDF) work guide to learn what you must include and what's required for each delivery method.

More Information:

- Standard Documentation Requirements for All Claims Submitted to DME MACs article
- Medicare Program Integrity Manual, Chapter 4 (PDF), section 4.7.3.1.1–4.7.3.1.3
- CERT webpage"

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-september-4-2025#_Toc207716159

National Correct Coding Initiative: October Update. CMS MLN Matters. September 4, 2025

Get the National Correct Coding Initiative (NCCI) fourth quarter edit files effective October 1, 2025, on these Medicare NCCI webpages:

- Procedure-to-Procedure Edits
- Medically Unlikely Edits
- Add-on Code Edits

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-september-4-2025#_Toc207716159

Complying with Medicare Signature Requirements Revised. CMS MNL Matters. September 4, 2025

CMS added information (PDF) on:

- Stamped signatures
- Artificial intelligence
- Signature attestations and logs

https://www.cms.gov/files/document/mln905364-complying-medicare-signature-requirements.pdf

Understanding the Railroad Medicare Medical Review Program. Railroad Medicare-Palmetto GBA. September 3, 2025

"**Event Date: 10-16 1:00 PM EDT - 2:00 PM EDT**

Do you have questions about Railroad Medicare's Medical Review (MR) Process? If so, register now for this informative session. We will provide you with an overview of our MR process for traditional postpayment, traditional prepayment, and Targeted Probe and Educate (TPE) reviews; review the process for additional documentation requests; identify service-specific codes that will be reviewed by our MR department this option year; and, finally, provide you with helpful resources."

https://palmettogba.com/rr/did/evm3vm7eai4v6n1016

Frequently Asked Questions (FAQs) About Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-On HCPCS Code G2211. CMS MLN Matters. August 21, 2025

"Healthcare Common Procedure Coding System (HCPCS) code G2211 (Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established))."

https://www.cms.gov/files/document/hcpcs-g2211-faq.pdf

Now Available: 2024 MIPS Performance Feedback and Final Scores. Quality Payment Program. September 9, 2025

"The Centers for Medicare & Medicare Services (CMS) has released Merit-based Incentive Payment System (MIPS) performance feedback and final scores for the 2024 performance year.

- Your 2024 final score determines the payment adjustment you'll receive in 2026.
- 2026 MIPS payment adjustments will be available in approximately one month.

How Do I Access Feedback?

- Sign in to the Quality Payment Program (QPP) website 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 2024 MIPS data.
- Click "View Feedback" on the home page and select your organization (Practice, Alternative Payment Model (APM) Entity, Virtual Group).
  - Practice representatives can access individual, subgroup, and group feedback.
  - Third party representatives can't access final feedback or payment adjustment information.

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."
"Review the 2024 MIPS Performance Feedback FAQs (PDF, 2MB) and 2024 Targeted Review User Guide (PDF, 2MB) for more information. "

Evaluation and Management Services — Revised. MLN Matters. September 18, 2025

RHW: Please read each highlighted section below for changes

P6 "Beginning January 1, 2025, you may bill the O/O E/M visit complexity add-on code, HCPCS code G2211, when you report CPT codes 99202–99205 or 99211–99215 with modifier 25 by the same practitioner on the same day as:

- An AWV
- Vaccine administration
- Any Part B preventive service, including the initial preventive physical examination furnished in the O/O setting"

P 6 "Intravitreal Eye Injections on the Same Date as an O/O E/M Visit Intravitreal drug therapy involves injecting medication directly into the eye to treat retinal diseases. Medicare considers intravitreal injections a minor surgical procedure. In general, we include payment for E/M services performed on the same date of service as a minor surgical procedure in the payment for the procedure and don't pay them separately.
The Medicare National Correct Coding Initiative (NCCI) Policy Manual, Chapter 1, section D has information on E/M services performed on the same date as a minor surgical procedure:

- If a procedure has a global period of 000 or 010 days, it's defined as a minor surgical procedure
- In general, we include E/M services performed on the same date of service as a minor surgical procedure in the payment for the procedure
- Include the decision to perform a minor surgical procedure in the payment for the minor surgical procedure, and don't report it separately as an E/M service
- A significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25
- The E/M service and minor surgical procedure don't require different diagnoses
- If you perform a minor surgical procedure on a new patient, the same rules for reporting E/M services apply
- The fact that the patient is new to the provider or supplier isn't sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure"

P 7 "Definition of Significant & Separately Identifiable E/M Services If a patient's condition requires a significant, separately identifiable E/M service, add modifier 25 to the appropriate level of E/M service. For example, examining both eyes at the time of an injection to 1 eye isn't a separately identifiable service. When you're performing a pre-op exam, evaluate the patient's fellow eye, and if that exam reveals a new diagnosis requiring a new management plan for a separately identifiable reason, we may consider it a separately identifiable service. The Medicare NCCI Policy Manual, Chapter 1, section E(b) has information on what's considered a significant and separately identifiable service performed on the same date as a minor surgical procedure:

- The CPT codebook defines modifier 25 as a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service"
- You may append modifier 25 to an E/M CPT code to indicate the E/M service is significant and separately identifiable from other services reported on the same date of service
- The E/M service may be related to the same or different diagnosis as the other procedures
- You may append modifier 25 to E/M services reported with minor surgical procedures with global periods of 000 or 010 days or procedures not covered by global surgery rules with a global indicator of XXX
- Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider or supplier shouldn't report an E/M service for this work

Medicare global surgery rules prevent the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure regardless of whether the patient is a new or established patient. For more information about global surgery requirements, review the Medicare Learning Network® Global Surgery booklet."

P 30-31 "Telehealth Services Section 2207 of the Full-Year Continuing Appropriations and Extensions Act, 2025 extended many of these flexibilities through September 30, 2025. Starting October 1, 2025, the statutory limitations that were in place for Medicare telehealth services before the COVID-19 public health emergency (PHE) will retake effect for most telehealth services. These include:

- Geographic restrictions
- Location restrictions on where you can provide services
- Limitations on the scope of practitioners who can provide telehealth service" …

Beginning January 1, 2025, an interactive telecommunications system may include 2-way, real-time, audio-only communication technology for any Medicare telehealth service furnished to a patient in their home if:

- The distant site physician or practitioner is technically capable of using an interactive telecommunications system
- The patient isn't capable of, or doesn't consent to, using video technology

Beginning October 1, 2025, the statutory limitations that were in place for Medicare telehealth services prior to the COVID-19 PHE will retake effect for most telehealth services. These include:

- Geographic and location restrictions on where you provide the services
- Limitations on the scope of practitioners who can provide Medicare telehealth services For dates of service in 2025, continue billing telehealth services with the POS you would bill for an in-person visit.

The POS options are:

- 02 — Patient not in their home when telehealth services are rendered.
- 10 — Patient in their home when telehealth services are rendered. POS 10 will continue to be paid at the non-facility rate.

Use modifier 95 for outpatient therapy services provided via telehealth by qualified physical therapists, occupational therapists, or speech language pathologists employed by hospitals. See the Telehealth & Remote Patient Monitoring booklet for more information. A complete list of 2025 codes is available. See the table below for a list of CPT or HCPCS codes

P32: Table 7: Services Added to the Medicare Telehealth Services List for 2025

https://www.cms.gov/files/document/mln006764-evaluation-management-services.pdf

CMS To Require Medicare Advantage Plans Disclose Provider Networks Next Year. AOA First Look. September 19, 2025

"Modern Healthcare (9/18, Early, Subscription Publication) reports CMS issued a final rule Thursday requiring Medicare Advantage insurers to submit provider directories next year. The agency 'intends to incorporate provider network information into the Medicare Plan Finder portal. This policy builds on a plan the agency announced last month to assemble provider lists it will add to the plan finder for the upcoming annual enrollment period. Insurer participation in that initiative is voluntary. CMS eventually aims to create a national provider directory.' The final rule stipulates that 'Medicare Advantage plans will have to submit their network lists by Jan. 1 and then once a year, plus updates every 30 days to reflect changes in provider participation. Insurers will not have to attest that they meet network adequacy standards. CMS did not specify when the information will be added to the Medicare Plan Finder.'"

Active Medical Reviews: August 2025 to July 2026. Railroad Medicare-Palmetto GBA. September 23, 2025

TPE Reviews: CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.

https://palmettogba.com/rr/did/atzp5u1000
https://palmettogba.com/rr/did/b2gi3pk71e#ls

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe

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

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

https://palmettogba.com/rr/did/b2gi3pk71e#ls

Service Type	CPT®/HCPCS Code	Code Description	Review Type
Evaluation and Management (E/M)	99213	Office/outpatient visit, established, (Usually 20–29 minutes time)	TPE
E/M	99214	Office/outpatient visit, established (Usually 30–39 minutes time)	TPE
E/M	99215	Office/outpatient visit, established, (Usually 40–54 minutes time)	TPE
Therapeutic Procedures	97110	Therapeutic exercises	Pre-payment
Therapeutic Procedures	97112	Neuromuscular reeducation	Pre-payment
Therapeutic Procedures	97113	Aquatic therapy/exercises	Pre-payment
Therapeutic Procedures	97116	Gait training therapy	Pre-payment

https://palmettogba.com/rr/did/cvcubayieq#ls

OTHER

RHW: Further clarification on the known downcoding programs from AOA TPC

1. Humana's downcoding program involved only the 99000 E&M codes and did not involve the 92xxx code set. They have removed ODs from 99xxx downcoding per conversations with the AOA Third Party Center.
2. Aetna has eliminated the 92xxx downcoding. ODs are still in their 99xxx program. This applies to both their Medicare Advantage products and their commercial products which are separate downcoding programs.
3. Cigna's new downcoding program which starts on October 1, 2025. Per Cigna, this program is solely based on over reporting of level 4 and 5 E&M codes (99204 - 99215). Per Cigna: "For the approximately three percent of providers who our records indicate as having a consistent pattern of coding at a higher E/M level for routine services compared to their peers, this new reimbursement policy will **not automatically** result in an adjustment of reimbursement for all claims. Instead, adjustments will be applied only to individual claim lines where the billing information does not substantiate the reported service level." https://providernewsroom.com/cigna-healthcare/new-reimbursement-policy-for-professional-evaluation-and-management-services-claims-effective-october-1-2025/

UnitedHealthCare Medical Policy Updates: September 2025

https://www.uhcprovider.com/en/resource-library/news/2025/mpub-updates-sep-2025.html?cid=em-providernews-2025nnb2-sep25

UHC Summary of Important Changes

UnitedHealthcare® Commercial and Individual Exchange Medical Glaucoma Surgical Treatments Policy Number: 2025T0443KK. Effective Date: October 1, 2025

Coverage Rationale

• Revised list of proven and medically necessary indications:

o Added:

♣ Goniotomy, trabeculotomy, canaloplasty (ab interno), or combined canaloplasty (ab interno) and trabeculotomy (e.g., OMNI® Surgical System, Streamline Surgical System) for adults (age 19 years or more) when used in combination with cataract surgery for treating mild to moderate open-angle glaucoma (OAG) and cataract in adults currently being treated with ocular hypotensive medication

♣ Laser trabeculoplasty (e.g., Argon, Selective)

♣ Laser iridotomy/iridectomy (e.g., Nd: YAG)

♣ Laser iridoplasty

♣ Laser ciliary body destruction

o Replaced "some glaucoma drainage devices (specifically XEN System, Ex-PRESS™, Molteno implant, Baerveldt tube shunt, Ahmed glaucoma valve implant, and Krupin-Denver valve implant) for treating refractory glaucoma when medical or surgical treatments have failed or are inappropriate" with "glaucoma drainage devices (e.g., XEN System, ExPRESS™, Molteno implant, Baerveldt tube shunt, Ahmed glaucoma valve implant, and Krupin-Denver valve implant) for treating refractory glaucoma when medical or surgical treatments have failed or are inappropriate"

• Added language to indicate all other FDA approved laser procedures [not listed in the policy as proven and medically necessary] are unproven and not medically necessary for treating any type of glaucoma due to insufficient evidence of efficacy

• Removed language indicating the following are unproven and not medically necessary for treating any type of glaucoma due to insufficient evidence of efficacy and/or safety:

o Canaloplasty (ab interno)

o Combined; canaloplasty (ab interno) and trabeculotomy (e.g., OMNI® Surgical System, Streamline Surgical System)
o Glaucoma drainage devices that are not FDA approved
o Goniotomy or trabeculotomy (for indications not listed as proven and medically necessary)

- Added CPT codes 0621T, 0622T, 0730T, 65855, 66710, 66711, 66761, and 66762

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/glaucoma-surgical-treatments-10012025.pdf

UnitedHealthcare® Oxford Clinical Glaucoma Surgical Treatments Policy: VISION 023.33
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/oxford/glaucoma-surgical-tx-ohp-10012025.pdf

UHC Surest Clinical Glaucoma Surgical Treatments Policy Number: 2025T0443KK
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/glaucoma-surgical-treatments-10012025.pdf

UHC UMR Glaucoma Surgical Treatments Policy Number: 2025T0443KK
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/glaucoma-surgical-treatments-10012025.pdf

UHC Commercial and Individual Exchange Retired Policy. Effective Date Sept 1, 2025

Title	Summary of Changes
Neuropsychological Testing Under the Medical Benefit	Retired policy; neuropsychological testing under the medical benefit no longer requires clinical review

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/commercial/medical-policy-update-bulletin-september-2025.pdf

UnitedHealthcare Commercial Reimbursement Policy Update Bulletin: September 2025
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/rpub/UHC-COMM-RPUB-September-2025.pdf

UHC Community Plan Reimbursement Policy Update Bulletin: September 2025
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/rpub/community-plan-reimbursement-update-bulletin-september-2025.pdf

UHC Individual Exchange/Individual and Family Plans Reimbursement Policy Update Bulletin: September 2025
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/exchange-reimbursement/erpub/UHC-Exchange-RPUB-SEPTEMBER-2025.pdf

UHC Medicare Advantage Plan Reimbursement Policy Update Bulletin: September 2025
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-reimbursement/rpub/UHC-MEDADV-RPUB-SEP-2025.pdf

UHC AARP Medicare Supplement Claims Address Change. August 14, 2025

"Use the correct mailing address to avoid claim processing delays
The mailing address has changed for AARP® Medicare Supplement claim submissions. Enter the new address into your system, and begin using it immediately to avoid delays with mail forwarding and claim processing.
UnitedHealthcare Claims Division
P.O. Box 1878
Southampton, PA 18966-9998
Health insurance ID cards may still include the old address during this transition and should not be used to submit claims.

How to submit claims

- The most efficient and accurate way to submit AARP Medicare Supplement claims is electronically — using payer ID 36273
- Paper claims are also accepted and should be mailed to the new address

Claims are typically processed/adjudicated within 10–14 days. Learn more about submitting claims for **AARP Medicare Supplement Plans** or **sign in** to the UnitedHealthcare Provider Portal to access insured member data."

https://www.uhcprovider.com/en/resource-library/news/2025/aarp-medicare-supplement-claim-changes.html?cid=em-providernews-2025nnb2-sep25

UHC Hispanic Heritage Month: Addressing Social Drivers of Health. August 11, 2025

"Screening patients for SDOH is critical to better understanding their needs and connecting them to life-enhancing resources

As a health care professional serving Hispanic patients, you play a pivotal role in addressing health disparities and promoting equal access to quality care. Health and well-being depend greatly on cultural and social factors. While a patient's socio-economic status, education and access to resources are critically important year-round, Hispanic Heritage Month gives us all an opportunity to review our commitment to improving these social drivers of health (SDOH) within communities.

Identify gaps while screening

You're in a unique position to identify and address the social drivers that affect your patients' health. By screening for SDOH, you can uncover critical needs that may otherwise go unnoticed. These screenings can reveal issues such as food insecurity, housing instability and lack of access to transportation. All of these can contribute to poor health outcomes.

Create awareness through reporting

When you report SDOH findings, you contribute to a more comprehensive and effective health care system. The data allows us and other organizations to better understand the needs of diverse populations. Your discoveries can help inform policy decisions, determine resource allocations and develop targeted interventions.

Connect patients to resources

Once you've identified and reported your patients' needs, connecting them to appropriate resources is essential to closing gaps in SDOH. This may involve collaborating with support networks, such as community organizations and social services. Creating awareness among these groups can initiate or advance services that will enhance the patient's quality of care, boost health outcomes and improve their overall well-being. As we work together, we can create a healthier and more inclusive future for all.

Support your Hispanic patients

Use our resources to address SDOH needs in your community:

- **Social Drivers of Health** – Tools for screening and reporting, links to training and education, and connections to useful resources
- **Cultural Competency** – Language interpretation services, tips for enhancing your provider directory listing, free training and education, and links to resources

https://www.uhcprovider.com/en/resource-library/news/2025/hispanic-heritage-month-social-drivers-health.html?cid=em-providernews-2025nnb2-sep25

Senator Joins Call Asking Cigna to Rescind New Downcoding Policy. Andress Cass. Becker's Payer Issues. September 11, 2025

"Sen. Richard Blumenthal is urging Cigna to rescind a new policy he said will create "onerous administrative burdens for physicians, needlessly raises costs for healthcare providers and jeopardizes patient care."

Beginning Oct. 1, Cigna's new Evaluation and Management Coding Accuracy policy will review CPT evaluation and management codes 99204-99205, 99214-99215, and 99244-99245 for billing and coding accuracy. Some services may be adjusted by one level when guidelines are not met.

"To better align with the American Medical Association's Evaluation and Management services guidelines, Cigna Healthcare will implement a new reimbursement and coding accuracy policy for E/M codes that are being inappropriately billed as a higher level," a Cigna spokesperson told *Becker's*. "This review will only apply to approximately 3% of in-network physicians who have a consistent pattern of coding at a higher E/M level compared to their peers. Claims will be individually reviewed for coding accuracy and payment may be adjusted by one level to meet AMA guidelines. Physicians may request reconsideration or appeal our decision if they feel the higher payment is appropriate."

Mr. Blumenthal outlined his concerns about the policy in a Sept. 11 letter to Cigna Health Chief Medical Officer Amy Flaster, MD. Among those concerns is a requirement that physicians file written appeals for each claim that is automatically downcoded. He said many physicians, especially those running small practices, “will have to sacrifice valuable time to file paperwork disputing billing errors.”

“This policy needlessly raises costs and threatens patient care and the stability of physician practices across the country,” he said in the letter.

The California and Texas medical associations have also urged Cigna to rescind the policy, echoing concerns it will increase administrative burdens, as well as create a barrier to appropriate reimbursement.

The medical associations said Cigna should halt the policy and instead focus on educating coding outliers. “ https://www.beckerspayer.com/policy-updates/senator-joins-call-asking-cigna-to-rescind-new-downcoding-policy/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

Rep. Fitzgerald Sends Letter To VSP Vision Care Requesting Information About Its Vertical Integration Practices. AOA First Look. September 16, 2025

“The Washington Examiner (9/15, Etzel) reports, “Rep. Scott Fitzgerald (R-WI), chairman of the House Judiciary Committee’s antitrust subcommittee, sent a letter on Monday, obtained by the Washington Examiner, to VSP Vision Care requesting a briefing about the company’s vertical integration practices, which critics argue pressure independent optometrist offices out of the market.” Fitzgerald wrote, “By consolidating market power and engaging in potentially anticompetitive conduct, VBMs may be harming patients as diminished competition can lead to higher prices, fewer alternatives, and limited access to independent providers.” The letter “comes three months after the American Optometric Association sent a cease and desist letter to VSP over its history of allegedly anticompetitive practices.” AOA Past President Steven Reed, OD, “wrote in a press release in June about the cease and desist letter that VSP’s model ‘sets up a downward spiral that ends badly for all involved.’” From AOA TPC: The Washington Examiner has posted this article on the inquiry: House GOP Eyes Antitrust in Vision Insurance Market: https://urldefense.proofpoint.com/v2/url?u=https-3A__www.washingtonexaminer.com_policy_healthcare_3808130_house-2Drepublicans-2Dantitrust-2Dvision-2Dinsurance-2Dmarket_&d=DwMGaQ&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=dIwov_e8hjI33xbaRkfIxRJ2WzE5DLy4cD3s7MLm3R0&m=dW1j6Y2Rd6rxLCB1u-vLehaEk7QzSOUJT2_MGpBPtbBLLk_n0sER6bjKO4iOT4Oy&s=2X5ddFXGrA8IqqGm0XIaTI2fmPTFVBsNF0SvMdnIKk4&e=

Lawmakers Debut Bill To Bar Insurers From Buying Medical Clinics. Becker’s Payer Issue. September 18, 2025

“Senate and House lawmakers have introduced a bill that would bar health insurers from buying independently owned clinics and require existing conglomerates to divert their provider businesses. “ [Patients Over Profits Act]
https://www.beckerspayer.com/payer/lawmakers-debut-bill-to-bar-insurers-from-buying-medical-clinics/?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

Medicare Advantage Enrollment Could Shrink Next Year, CMS Says. AOA First Look. September 29, 2025

Modern Healthcare (9/26, Tepper, Subscription Publication) reported, “Medicare Advantage enrollment could slip next year, the Centers for Medicare and Medicaid Services announced Friday.” Health insurers “project Medicare Advantage membership will fall from 34.9 million this year to 34 million in 2026, CMS said in a news release.” Additionally, “insurers...predict that Medicare Advantage will lose ground to fee-for-service Medicare next year.” Modern Healthcare adds, “The privatized program surpassed traditional Medicare in 2023 but will cover 48% of beneficiaries in 2026, down from 50% this year, according to industry estimates reported to CMS.”
Article: https://www.modernhealthcare.com/insurance/mh-medicare-advantage-enrollment-drop-cms/

Tupelo, Miss.-based North Mississippi Health Services went out-of-network with UnitedHealthcare Medicare Advantage on June 1[2025]. North Mississippi Health Service. June 10, 2025

"North Mississippi Health Services (NMHS) facilities and providers have terminated agreements with United Healthcare (UHC) Medicare Advantage and Medicaid required Dual Special Needs Medicare Advantage Plans. … NMHS remains in network for commercial/employer sponsored plans (including UMR administered plans), UHC Federal Marketplace plans, UHC MS CAN and CHIP.

Effective June 1, NMHS facilities and providers are now considered out of network for all United Healthcare Medicare Advantage PPO and HMO plans.

NMHS will continue to schedule services for United Healthcare Medicare Advantage PPO plans, as the PPO plans offer out-of-network benefits.

United Healthcare Medicare Advantage HMO plans do not cover out-of-network facilities and providers. .."

https://www.nmhs.net/News-and-Media/Press-Releases/2025/NMHS-Terminates-United-Healthcare-Medicare-Advantage-Contract