

MISSISSIPPI MEDICAID

TrueCare and EyeMed Credentialing of Providers

RHW: An issue has come to the attention of the MOA that could be impacting payment of medical claims under TrueCare. All providers must be credentialed with both TrueCare and with EyeMed. Apparently EyeMed issued a provider number to some providers that was ONLY meant to facilitate their tracking of EyeMed providers under the new TrueCare plan. If you are receiving denials from TrueCare stating you are an out-of-network provider, please contact TrueCare credentialing in order to become a medical eye care provider.

<https://www.mstruecare.com/ms/providers/>

Message from TrueCare 12/02/2025

TrueCare would like to remind all vision providers who are currently contracted with EyeMed for routine vision services, and also performing what may be non-routine vision care services for TrueCare Members that without a medical contract directly with TrueCare providers may experience claim denials for no prior authorization.

We want to ensure that all providers who intend to perform both routine and non-routine vision services are contracted with TrueCare directly so that these non-routine vision services can be paid. Providers can utilize the online application process <https://secureforms.mstruecare.com/HealthPartnerContract> to submit an application to us, and can contact us via Provider Services: 1-833-230-2174, Monday through Friday, 7:30 a.m. to 5:30 p.m. Central Time (CT). If you have any questions or concerns about your contract effective date, please reach out to our health partner specialist by 12/31/2025 (Lexie Harrison) @ Cameron.Harrison@mstruecare.com

Request for Information Email Inbox to be Phased Out. Mississippi DOM Late Breaking News. October 27, 2025

“As part of our ongoing efforts to streamline requests and improve efficiency at the Mississippi Division of Medicaid, the Request for Information email inbox (RFI@medicaid.ms.gov) is being phased out and is no longer actively monitored. Please see below for updated instructions on how to submit your request through the appropriate channel to ensure an accurate and timely response.

Helpful Information

For guidance and support for your specific needs, please contact your Provider Field Representative for assistance. You can access the list of Provider Field Representatives, which includes the email address and phone number for each representative at the following link: [Provider Field Representatives Map and Contact List](#). You will find detailed contact information for external information requests on the [Contact](#) page of the Mississippi Division of Medicaid website. If you are looking for a specific form, be sure to check out our updated list of forms on the [Forms](#) page of our website.

Be sure to note the Provider drop down for quick access to common contact information.

Common Forms/Inquiries

- [Managed Care Provider Inquiry and Issue Form](#)
- [Eligibility Data Match Requests](#) (New)
- [Claim or Lein Requests](#) (New)

We continue to appreciate your commitment to providing quality care to Medicaid beneficiaries and encourage you to utilize these resources for further assistance. For additional support, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222.”

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

View Job Aid to Adjust or Void a Claim Via the Provider Portal. DOM Late Breaking News. November 17, 2025

“The Mississippi Division of Medicaid (DOM) has published a new job aid: “Adjust or Void a Claim Via the Provider Portal.” This resource provides step-by-step guidance for providers on how to adjust or void previously paid claims.

Key Requirements for Adjusting or Voiding a Claim:

- Only paid claims can be adjusted or voided. Denied claims cannot be adjusted; a new claim must be submitted.
- Claim Status must be ‘Finalized Payment’ before initiating an adjustment or void.
- Voiding a claim removes the original claim and payment from history and may trigger Accounts Receivable (AR) for recoupment.
- Adjusting a claim allows corrections to billing codes, service dates, units, modifiers, place of service, referring provider ID, diagnosis codes, or charges.
- Attachments from the original claim do not auto-populate; providers must upload required documents again.
- Adjustments may result in additional payment or AR setup for recoupment.
- Use Print Preview before confirming submission to ensure accuracy.

Access the full job aid here: <https://medicaid.ms.gov/wp-content/uploads/2025/11/PRP-101-Adjust-or-Void-a-Claim-Via-Provider-Portal-v0.2.pdf>





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/2025/09/Q3-2025-PROVIDER-FIELD-REPRESENTATIVES_Map-and-By-County_v1.0.pdf”

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

Magnolia Health Ambetter Scheduling Standards. Magnolia Health News. November 7, 2025

STANDARDS FOR SCHEDULING

To ensure our members receive services for medical and behavioral health appointments in a timely manner, below are the Appointment Availability Standards we ask our providers to implement accordingly. These can also be found in the provider manuals.

+ After Hours - All Providers			
After Hours (Passing Standards)			
<ul style="list-style-type: none">• Answering service or system that will page physician• Answering system with option to page physician		<ul style="list-style-type: none">• Advice nurse with access to physician• Answering service that will page the provider after a message is left	
+ Ambetter			
 PRIMARY CARE & PEDIATRIC	 SPECIALIST	 OBGYN	 BEHAVIORAL HEALTH
<ul style="list-style-type: none">▶ Urgent Care: Within 24 hours of member’s call▶ Non-Urgent/Sick Care: Within 48 hours▶ Routine: Within 15 business days of request	<ul style="list-style-type: none">▶ Urgent Care: Within 24 hours▶ Routine: Within 30 business days	<ul style="list-style-type: none">▶ Urgent Care: Within 24 hours▶ Routine: Within 30 business days	<ul style="list-style-type: none">▶ Non-Life-Threatening Psychiatric Emergency: Within 6 hours▶ Urgent: Within 48 hours▶ Routine (Initial Assessment): Within 10 business days▶ Routine Follow Up Care: Within 10 business days

<https://mailchi.mp/a5b453d679ca/pooscgsvfh-48961?e=6d63e1c4a4>

Division of Medicaid's State Plan Amendment 25-0019-CHIP Benefit Limits. DOM. November 10, 2025

"From: **DOMPolicy** <DOMPolicy@medicaid.ms.gov>

Date: Mon, Nov 10, 2025 at 4:39 PM

Subject: MS SPA 25-0019-CHIP Benefit Limits approved by CMS

The Division of Medicaid's State Plan Amendment 25-0019-CHIP Benefit Limits has been approved by the Centers for Medicare and Medicaid Services (CMS). You can view the CHIP SPA and State Plan via this link: [Children's Health Insurance Program \(CHIP\) State Plan](#)

[MS SPA 25-0019-CHIP Benefit Limits approved by CMS](#)

State Plan Amendment (SPA) MS-25-0019 CHIP Benefit Limits was submitted to allow the Division of Medicaid (DOM) to remove annual and lifetime limits on benefits in CHIP as required by the Medicaid & CHIP Eligibility and Enrollment final rule, effective June 1, 2025.

Office of Policy

Office of the Governor, Division of Medicaid

550 High Street, Suite 1000 | Jackson, MS 39201

Phone (601) 359-3984

Email DOMPolicy@medicaid.ms.gov

Website <http://www.medicaid.ms.gov>"

New Claim Denial Reason for Enrollment - Magnolia MSCAN & CHIP. Magnolia Health News. November 7, 2025

Magnolia is implementing a new claim denial reason related to provider enrollment. This update affects Billing Providers submitting claims for Individual Rendering Providers that are not linked or affiliated to the billing group with Medicaid.”

What You’ll See on Your EOP:

Denial Code: EXNK

Message: DENY: RENDERING PROVIDER NOT ENROLLED UNDER BILLING GROUP

Steps to Resolve the EXNK Denial:

1. **Review Your Billing Relationships:**
 - Identify all Billing NPIs (Group or Providers) you submit claims under.
2. **Verify Medicaid Affiliation:**
 - Confirm that you are enrolled and properly affiliated to each Billing NPI through Gainwell Technologies, the Medicaid fiscal agent.
3. **Update Enrollment if Needed:**
 - If you are not affiliated with a Billing NPI:
 - Log into the Gainwell Provider Portal.
 - Submit the necessary updates or affiliation requests.
 - Ensure all information is accurate and complete.
4. **Confirm Affiliation Completion:**
 - After submitting updates, verify that your enrollment affiliation is active and reflects correctly in the Medicaid system.
5. **Resubmit Claims**
 - Resubmit denied claims within 180 days of the date of service.
6. **Monitor Your EOPs:**
 - Continue to check your Explanation of Payment (EOP) for any denial codes.
 - If you see EXNK, revisit your enrollment status and correct any issues.

We encourage all providers to review their current Medicaid enrollment status to avoid claim denials.

If you have questions, please contact your Provider Engagement Representative or Provider Services at 877-236-0751.

<https://mailchi.mp/a5b453d679ca/pooscgsvfh-48961?e=6d63e1c4a4>

CMS, NOVITAS, RAILROAD MEDICARE

2026 Medicare Parts A & B Premiums and Deductibles. CMS. November 14, 2025

Medicare Part B Premium: \$202.90

Medicare Part B Deductible: \$283.00

<https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles>

Medicare Participation Announcement for CY 2026: Decide by December 31. CMS MLN Connects. November 14, 2025

“As you plan for next year, CMS reminds you of the advantages of participating in Medicare:

- You’re paid the full Medicare Physician Fee Schedule allowed amount. If you’re a non-participating provider, Medicare pays 5% less than the Medicare Physician Fee Schedule allowed amount.
- Medicare pays you directly (on an assignment-related basis).
- Medicare forwards claim information to Medigap (Medicare supplement coverage) insurance (if any).

By December 31, 2025, all physicians, practitioners, and suppliers – regardless of their Medicare participation status – must decide whether to participate for CY 2026.

You don’t need to do anything if you’re:

- Already participating in Medicare, and you want to continue your participation
- Not currently participating, and you don’t want to participate

See the [Annual Medicare Participation Announcement](#) webpage for more information on how to change your Medicare participation.

National Plan and Provider Enumeration System (NPPES) Taxonomy

Please check your data in [NPPES](#) and confirm that it still correctly reflects you as a health care provider with the appropriate taxonomy and correctly reflects your current practice address. Incorrect data in NPPES may lead to unnecessary inquiries about your credentials and delay enrollment with Medicare and health plans.

National Plan and Provider Enumeration System (NPPES) Taxonomy. CMS MLN Connects. November 14, 2025

“Please check your data in NPPES and confirm that it still correctly reflects you as a health care provider with the appropriate taxonomy and correctly reflects your current practice address. Incorrect data in NPPES may lead to unnecessary inquiries about your credentials and delay enrollment with Medicare and health plans”

<https://nppes.cms.hhs.gov/login>

Sight Science TearCare Notice to Providers. November 5, 2025

RHW: Please note that 0563T is not listed in the [2025 Carrier Fee Schedule](#) so I am assuming this change will take effect with the 2026 Carrier Fee Schedule when published.

“We’re pleased to share a significant milestone: The TearCare® System is now reimbursed in the [Novitas Solutions](#) and First Coast Service Options Medicare Administrative Contractor (MAC) jurisdictions through a set fee schedule amount. This recognition follows a jurisdiction-specific fee schedule update, recognizing the role of TearCare® in treating evaporative dry eye disease caused by Meibomian Gland Disease (MGD). TearCare® is designated by [CPT code 0563T](#), which may be reimbursed in certain jurisdictions when deemed medically necessary. ¹ With clinically proven outcomes, this move brings us closer to fair and widespread access to interventional care. ...”

<https://ww1.broadcastmed.com/index.php/email/emailWebview?email=ODI0LVhPRy0wNTQAAAGd-ZHBSAQudsFEOBGsYzJl4LrUVN0--GtC1qE325OlwW-ytnrYWzrrLlaOms5M5yfKJn31HYRm9z7nPIRlqOBiTY61tADfdwyBQk>

Update on Processing of Medicare Claims Impacted During the Government Shutdown. CMS MLN Connects. November 21, 2025

“Multiple expiring Medicare statutory payment provisions lapsed on October 1, 2025, due to the absence of Congressional action. With the passage of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Pub. L. 119-37), Congress retroactively restored many of these payment provisions, effective from October 1, 2025, through January 30, 2026. This includes retroactively restoring the suspension of statutory provisions that restrict payment for telehealth services provided to beneficiaries in their homes and outside of rural areas.

During the shutdown, in general, the Medicare Administrative Contractors (MACs) processed claims consistent with the pricer software, fee, and payment schedules available on cms.gov. CMS has instructed the MACs to perform mass adjustments to any paid claims that are inconsistent with the most recent Congressional action,

including a payment adjustment for low volume inpatient hospitals and a payment adjustment for the Medicare-dependent hospital program.

On November 6, 2025, CMS instructed the MACs (see [Update on Processing of Telehealth and Acute Hospital Care at Home Claims](#)) to return a subset of telehealth claims submitted on or before November 10, 2025, that, at that time, were no longer payable because the statutory provisions temporarily suspending various Medicare telehealth requirements expired on October 1, 2025, or were claims CMS could not identify as payable under current law. For professional claims, those claims were returned with the following messages: CARC 16 and RARC M77. **These claims are now payable, provided they meet all applicable Medicare requirements. Practitioners may resubmit those returned claims to CMS, as well as submit any other telehealth claims held in anticipation of possible Congressional action.** Practitioners are also encouraged to identify which beneficiaries were charged for telehealth services with dates of service on or after October 1, 2025, that are retroactively payable and instead submit applicable claims to Medicare, refunding any overpayment to beneficiaries. Our instruction to practitioners to append the GY modifier on certain telehealth claims is rescinded and providers may resubmit previously denied claims. ...

Facilities, practitioners, and suppliers should be observing a return to normal processing operations over the coming days across the MACs and do not need to contact the MACs unless you observe specific discrepancies.”

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-november-21-2025#_Toc214550139

CMS Telehealth FAQs-2026. Updated November 11, 2025

Q1: Do Medicare beneficiaries need to be located in a rural area and in a medical facility in order to receive Medicare telehealth services?

A1: Through January 30, 2026, beneficiaries can receive Medicare telehealth services anywhere in the United States and territories. Starting January 31, 2026, except for behavioral health services, beneficiaries will generally need to be in a medical facility and in a rural area to receive Medicare telehealth services.

...

Q8: Which place of service code should I use for telehealth services?

A8: Physicians and/or practitioners should use POS 02 for Telehealth Provided Other than in Patient’s Home or POS 10 for Telehealth Provided in Patient’s Home (which is a location other than a hospital or other facility where the patient receives care in a private residence). In the CY 2024 PFS final rule, we finalized that, starting January 1, 2024, claims for Medicare telehealth services provided to patients in their homes are to be paid at the non-facility payment rate.

<https://www.cms.gov/files/document/telehealth-faq-updated-11-26-2025.pdf>

Medicare Information for Patients. CMS Region IV Outreach Webinar. December 1, 2025

RHW: Note - Medicare Open Enrollment for patients ends December 7, 2025, with changes effective January 1, 2026. Medicare.gov is the website for patients to use for enrollment. This year, if a patient discovers that their plan listed their doctors as in network, but that provider is actually NOT in network, the patient can change to a different plan outside of open enrollment.

Special Enrollment Periods

You can make changes to your Medicare Advantage and Medicare drug coverage when certain events happen in your life, like if you move or you lose other coverage. These chances to make changes are called Special Enrollment Periods. There are many events that may qualify you for a Special Enrollment Period.

The types of changes you can make and the timing depend on your life event. If you have questions or need help making enrollment changes, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CMS states the following:

2025 Open Enrollment Core Campaign Messages

- The Medicare Open Enrollment period is from October 15 through December 7.
- Medicare.gov (and 1-800-MEDICARE) are the official sources for Medicare Open Enrollment.
- Plans can change every year. Your health needs can change, too. By comparing all your options, you could save money, find better coverage, or both.
- Log in or start an account at Medicare.gov to do a personalized, side-by-side comparison of health and drug plans.
- Make sure your prescription drugs are covered.
- New this year:
 - Check which plans cover your favorite doctors.
 - More easily and securely log into your Medicare account.
 - You can search all the plans in your area for the extra benefits that are important to you, now including weight management programs.

What's New in the Medicare Program for 2026?

- Medicare is negotiating with drug companies to help people pay less for these 10 brand-name prescription drugs starting January 1, 2026:
 - Eliquis, Jardiance, Xarelto, Januvia, Farxiga, Entresto, Enbrel,, 2026 Imbruvica, Stelara, and Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill
- \$2,100 limit on out-of-pocket drug costs for people with Medicare Part D (up from \$2,000 in 2025)
- Expanded screening for colorectal cancer: Medicare now covers computed tomography (CT) colonography
- Patient-focused service to help people manage health needs: Medicare now pays for Advanced Primary Care Management services

What's Changing for 2026?

Telehealth

- As of October 1, 2025, you must be in an office or medical facility in a rural area (in the U.S.) for most telehealth services
- You can still get certain Medicare telehealth services outside of rural areas, including End-Stage Renal Disease (ESRD) visits for home dialysis, services related to an acute stroke, and services related to mental and/or behavioral health disorders (including substance use disorders)
- Medicare Advantage Plans and some providers may offer more telehealth benefits than the basic Original Medicare coverage

OTHER

Telehealth Replaces 74% Of Office Visits, Data Indicate. AOA First Look. November 26, 2025

“[Managed Healthcare Executive](#) (11/25, Lutton) reports, “Telehealth replaces 74% of office visits, according to the operational [analysis](#) of telehealth utilization from 2019 to 2023, across nine health systems.” That “includes 7.2 million patients, 1.67 million of whom were Medicare beneficiaries.” This “report includes 10 Medicare payment models, representing 30 states, plus Washington, D.C.” The research “was conducted by the American Telemedicine Association (ATA) Center of Digital Excellence (CODE).”

Original Article: https://info.americantelemed.org/hubfs/CODE/ATA%20CODE%20Multi-System%20Analysis_%20Real-World%20Operational%20Medicare%20Telehealth%20Utilization%20Patterns.pdf

NEW! AOA Codes for Optometry Available As Member-only Digital Resource. AOA First Look. November 6, 2025

“The AOA offers its **2026 Codes for Optometry** and **Common Optometric ICD-10 Codes** quick-reference card as digital downloads exclusively for AOA members. These resources have been updated to reflect the latest updates from CPT, ICD-10 and HCPCS, and are essential coding resources for optometric practices.

- [AOA Codes for Optometry](#)
- [Common Optometric ICD-10 Codes](#)

As an AOA member, you have access to a collection of resources, online education and expert advice that can help practices navigate medical coding and reimbursement.

Here are three other AOA member-benefit resources:

1. [AOA Coding Today](#). Use this online database to quickly and accurately address your coding questions in real-time, from CPT to ICD-10 and HCPCS, or enjoy region-specific coding information.
2. [Ask the Coding Experts](#). Have a complicated question or seeking clarification on a best practice? [Submit your questions to AOA’s Coding Experts](#) for tailored coding and reimbursement insights or read their [frequently asked questions and answers column in the AOA Focus content hub](#).
3. [AOA EyeLearn](#). Do you or your staff want to learn more about coding and reimbursement issues, and how they affect your practice? The AOA EyeLearn Professional Development Hub [offers self-paced, recorded webinars](#) to bring your team up to speed.

[Learn more](#) about how your staff can earn a specialty certification in optometric coding. “

UnitedHealthcare Limits Remote Patient Monitoring Coverage To Heart Failure, Hypertension During Pregnancy. AOA First Look. November 10, 2025

[Fierce Healthcare](#) (11/7, Beavins) reported, “Despite the momentum of remote monitoring uptake, UnitedHealthcare has quietly pushed out a massive change to its coverage policies that could impact thousands of Medicare beneficiaries.” The company’s “new policy says remote patient monitoring (RPM) is only medically necessary in two instances: to treat chronic heart failure and hypertension during pregnancy.” The policy “explicitly says the use of RPM for Type 2 diabetes and hypertension – two of the most popular uses of RPM – will no longer be covered.” In order “to back its new policy, the insurer pointed to slipshod evidence and misstated medical guidelines, legal experts say.”

<https://www.fiercehealthcare.com/regulatory/rfk-jr-wants-end-chronic-disease-epidemic-united-healthcare-plans-strip-members-popular>

United Health Care Updates, Oxford Health Updates, Surest Updates, UMR Updates

Remote Physiologic Monitoring (RPM) Policy Number: 2026T0662A Effective Date: January 1, 2026.

Commercial, Individual Exchange Plans, Community Plans

Remote Physiologic Monitoring (RPM) is proven and medically necessary when the individual has one or more of the following conditions:

- Heart failure (HF)
- Hypertensive disorders of pregnancy (HDP)

Remote Physiologic Monitoring (RPM) is unproven and not medically necessary due to insufficient evidence of efficacy for all other indications not listed as proven, including but not limited to:

- Anxiety
- Chronic obstructive pulmonary disease (COPD)
- Gestational diabetes
- Schizoaffective disorder
- Hypertension (HTN) other than hypertensive disorders of pregnancy (HDP)
- Bipolar disorder
- Depression • Diabetes mellitus (DM)
- Obstructive sleep apnea (OSA)

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/remote-physiologic-monitoring-01012026.pdf>

UHC Medicare Advantage: Remote Physiologic Monitoring (RPM) Policy Number: MMP395.01 Effective Date: January 1, 2026

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/mamp/remote-physiologic-monitoring-mamp-01012026.pdf>

UHC Reimbursement Policy Update Bulletins: December 2025

<https://www.uhcprovider.com/en/resource-library/news/2025/rpub-dec-2025.html?cid=em-providernews-2025nnb2-dec25>

UHC Medicare Advantage Plans Requiring Prior Authorization for Services

- In 2026, most UnitedHealthcare Medicare Advantage health maintenance organization (HMO) and point of service (POS) plans are referral plans. You can check plan referral requirements [online](#).
- Starting Jan. 1, 2026, most members enrolled in UnitedHealthcare Medicare Advantage HMO/POS plans will be required to obtain a referral from their primary care provider (PCP) before accessing certain specialist services in outpatient, office or home settings. Referrals must be submitted by the PCP to UnitedHealthcare prior to the specialist visit. This also applies when members of HMO/POS plans are traveling and accessing the National Network. Learn more in our [2026 Medicare Advantage Referral Requirements Guide](#)
- **HOWEVER:** The following services DO NOT need a referral from the member's PCP to be submitted to UnitedHealthcare: ... Any service from a network obstetrician/gynecologist, chiropractor, audiologist, oncologist, hematologist, nuclear medicine, neonatology, emergency medicine, nutritionist, podiatrist, **optometrist, ophthalmologist, optician**, radiologist, therapeutic radiologist or infectious disease specialist

https://chameleon-4-prod.s3.amazonaws.com/clients/39-64ecae4085df9/courses/5591-68cc106740b24/prod/index.html#/en-US/*/lesson/2/1

Humana Medicare Advantage Medically Necessary Contact Lens Denials. AOA First Look. November 3, 2025

Plan: Humana

Member Doctor Concern/Complaint: Medically Necessary Contact Lens Denials for Humana Medicare Advantage Patients.

Action: AOA engaged the plan.

Result: Humana took action swiftly and identified an issue with claims processing through EyeMed. Claims processing corrections have been made. Doctors who had claims denied should refile those claims. The AOA thanks Humana for their work to resolve this issue.

INTERESTING READ

What 'I'm Fine' Really Means: An Open Letter From a Thyroid Eye Disease Patient. Ophthalmology Times. November 7, 2025

“Thyroid Eye Disease (TED) can progress even as patients minimize their symptoms. Hear from a real TED patient and advocate, Gail, as she describes years of missed connections before her diagnosis and how asking the right questions could have changed her experience. Her story, *What 'I'm Fine' Really Means*, underscores the importance of assessing both the physical and emotional impact of TED. “

https://www.opthalmologytimes.com/view/what-im-fine-really-means-an-open-letter-from-a-thyroid-eye-disease-ted-patient/?ekey=RUtJRDpDNjdFOUQwQy04MTU5LTQyNEUtQjExMCOyMEUxNTM4N0JEMjI%3D&utm_campaign=d00-00-0040934&utm_medium=email&_hsenc=p2ANqtz--9JyhJQpR7x5w2LIHxZmN5_m-jJKgsWsSWeq1w89O6OYcDSr5hmvI7W-zOX1zb36TBPjtq8r2jWD8Dj3Zs5sBUiGAqNw&_hsmi=390876872&utm_source=hubspot