

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
FOR MEDICAID SERVICES

IN RE: DENTAL TAC

HELD VIA ZOOM

DATE:

MAY 10, 2024

2:00 P.M.

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A T T E N D E E S:

Garth Bobrowski, DMD, Chairman

Joe Petrey, DMD

Carol Jean Braun, DMD

(and many more were on ZOOM)

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May 10, 2024

2:00 p.m.

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DR. BOBROWSKI: Do we have a quorum?

MS. BICKERS: I saw yourself, Joe and Carol
log in, so that should give you a quorum.

DR. BOBROWSKI: I saw we had Joe, okay.

Well, hello. I want to thank you first and
I want to welcome everyone to the Medicaid
Dental TAC Meeting. I sent out the agenda
the other day and I noticed a typo, but we
will get to it later. It may not be any
big significance on that. But we'll do the
roll call.

Let's see. Dr. Petrey?

DR. PETREY: Here.

DR. BOBROWSKI: Dr. Braun?

DR. BRAUN: Here.

DR. BOBROWSKI: And this is Garth Bobrowski
and I'm here.

Dr. Gray? I hadn't seen him in the
picture docket yet.

MS. BICKERS: I haven't seen him come in
yet.

DR. BOBROWSKI: Okay. Well, we've got a

1 quorum so we'll get started. And we will
2 have the approval of the minutes from the
3 last meeting from February the 9th, '24.

4 DR. PETREY: Make a motion to approve the
5 minutes.

6 MS. BRAUN: Second.

7 DR. BOBROWSKI: All in favor say Aye.

8 (All Members vote "Aye".)

9 DR. BOBROWSKI: And those are approved.

10 Thanks, Everyone.

11 And before we get into our official
12 meeting here, I wanted to say
13 congratulations to Nicole Allen. She has
14 received a promotion and today is going to
15 be her last day with our Kentucky TAC
16 meeting, so we want to congratulate her.
17 She's been working with us for nine years
18 and we appreciate all that -- Nicole, all
19 that you have done, you know, for the
20 Medicaid population and for helping with our
21 TAC.

22 And the other thing, I want to wish
23 all the ladies and the moms a Happy Mother's
24 Day this weekend. I can't think of a
25 greater, more significant title than Mom.

1 So congratulations to all you moms out
2 there. I hope you have a great and
3 wonderful day.

4 We've got a pretty full agenda, so I'm
5 going to move on to Old Business. I just
6 wanted to bring up -- we talked a little bit
7 about it before -- I guess it's a DMS rule
8 on -- it's changed a little over the years
9 from, you know, if somebody breaks off a
10 front tooth, and you fix it and they might
11 be a bruxer or -- and, see, in years past on
12 the adults we could not -- Medicaid did not
13 cover a bite guard, and they did not cover
14 crowns. So, you know, sometimes these folks
15 or bruxers would break these off again.
16 Well, my question is does this become a
17 non-covered service that the patient then
18 would have to be paid for -- that they would
19 pay for, or according to the wording of a
20 20140, it calls that we can do an anterior
21 resin filling code to get paid for that
22 service, but there's really no clear
23 definition on that. And I didn't know if
24 anybody from DMS had an answer to that one
25 yet or -- and some of these -- there's going

1 to be a lot of questions today. We may not
2 have time for answers, but we'll -- if we
3 don't, we'll bring it up at the next
4 meeting. But I didn't know if anybody had
5 any ideas on how to cover that or what code
6 to use. So anybody got any ideas?

7 MS. MADRAS: Hi, this is Ashley Madras with
8 Kentucky Medicaid.

9 So when we went over the Dental TAC
10 agenda, we weren't really sure which code
11 was being talked about on that certain
12 question. So what I will have to do is I'll
13 have to take that back to management and ask
14 them how to -- is the code that you are
15 wanting to know about is that 20140? Is
16 that the one that you are wanting to
17 specifically know about?

18 DR. BOBROWSKI: Well, that's an option
19 because the -- but the other qualifier is,
20 is that on the filling codes it's got a
21 wording in there that it will pay for a
22 filling on the same tooth once a year.
23 Well, and a lot of our folks have got --
24 they've got fillings on top of fillings.
25 And, you know, we were just wondering how

1 can the dentist do this service. And it
2 might be 11 months, it lacks one month
3 being a year since that tooth was fixed,
4 and well they, you know, had a sucker in
5 their mouth and broke it off, bit on a
6 piece of candy and broke it off or chipped
7 it. I guess if we smoothed it for that
8 time being, we would turn in a 911 because
9 it was cutting their lip or their tongue.
10 But I was just kind of wanting to see if we
11 could get that one cleared up for our
12 dental providers out there.

13 But, yeah, that will be fine if you
14 want to bring some information back to the
15 next meeting. That's fine.

16 MS. MADRAS: And any questions that you
17 have today, just if you have any specific
18 codes or examples or claims that you would
19 like us to look at, they told me just to
20 have you e-mail it to that division of
21 healthcare policy e-mail. That way we can
22 research it better for you guys.

23 DR. BOBROWSKI: Okay. Do you have that
24 e-mail address?

25 MS. MADRAS: Yes. I can put it in the chat

1 for you.

2 DR. BOBROWSKI: Okay, thanks.

3 MS. MADRAS: You're welcome.

4 DR. BOBROWSKI: Another thing we were

5 looking at was -- I was kind of going back

6 on some questions that we had had in the

7 past, is just like the utilization reports

8 on adult root planning. And we've gotten

9 some folks that, you know, they were

10 denied, and I didn't -- and I apologize on

11 my end of it. I didn't ask the dentist

12 more details. Well, did they give you a

13 reason why that was denied or -- because,

14 you know, most usually, I mean, it's either

15 they didn't have enough qualifying

16 periodontal pocket numbers, or the X-rays

17 were not adequate to show either bone loss

18 or tarter. So I need -- when dentists call

19 me about issues, or text me about it, I

20 need to do a little bit more investigative

21 work myself, so that it's more clear so

22 that I can ask the appropriate question and

23 get it to the appropriate department. But

24 that was one of the codes that we were

25 looking at was -- and I appreciate DMS and

1 Commissioner Lee for the work that they are
2 doing on getting a few more of these
3 periodontal disease codes in there. And I
4 know once before I had mentioned to the
5 Commissioner, said, well, let us treat the
6 disease. Let us help people. And I think
7 that's coming around.

8 Now, the tie-in question with that
9 was -- and this is not aimed at any, you
10 know, one person, group or MCO, but what can
11 we as a TAC or as a group look at
12 streamlining prior authorizations. They --
13 according to the paperwork and spreadsheet
14 that's on the DMS website, like for dentures
15 it doesn't call for a prior authorization on
16 dentures or partial dentures, but it is
17 required through the MCOs. So, you know,
18 just that little bit of differences there
19 and, you know, and I know -- and on some of
20 those we are required to send in a Panorex;
21 some of them we are not.

22 And the other one -- there was a new
23 code that was added in, the D -- let me pull
24 it up here -- 4346, and we appreciate that.
25 That's one that can really help a lot of

1 people, the D4346. The only thing that I
2 noticed on it, that it requires a prior
3 authorization. Now, I'll give you an
4 example. It doesn't happen real often, but
5 periodically we'll have folks that come in,
6 I mean, they are sick. They are running a
7 fever. They can't hardly open their mouth.
8 They can't eat. They can't drink. But
9 they're in -- their gums are so infected --
10 and, again, because of lack of brushing,
11 flossing, and dental cleanings typically --
12 and a lot of times we just got to start them
13 with antibiotics and have them come back
14 anyway. But now there's times when some of
15 those folks, they just need to be numbed and
16 scaled, cleaned, get that stuff out from
17 under their gums. But then we've got --
18 according to this, I've got to reschedule
19 them and get the prior authorization done
20 and then have them come back. So that means
21 it's two appointments that these folks have
22 got to -- potentially have to take off work
23 again. But, I mean, such is life, you know,
24 even with the medical doctor sometimes we
25 got to go see what the problem is and come

1 back and treat it. But I just wanted to
2 give you that example of, you know, why --
3 why do we need to have a prior
4 authorization.

5 Now, does any TAC member or MCO have
6 any comments on that?

7 DR. RICH: Yeah, Garth, this is Dr. Rich
8 with United Healthcare. With UHC you can
9 submit the prior authorization information
10 with the claim, and if it qualifies we will
11 pay the claim regardless of whether the
12 prior authorization was done in advance or
13 not.

14 DR. BOBROWSKI: Okay.

15 MS. MEDINA: Yeah, and this is Christina
16 with DentaQuest. Pretty much the same, you
17 know. For those type of cases we'll do the
18 review as part of the claims payment, under
19 prepayment review, so it doesn't
20 necessarily -- you know, we don't want to
21 be obstruction to care. There's no need to
22 have to reschedule the member, have them
23 come in. You know, some of those cases,
24 they need to be addressed at that point, so
25 there's allowances for that.

1 DR. BOBROWSKI: Okay.

2 DR. CAUDILL: Garth, this is Jerry. We're

3 the same. We have always had the policy

4 that if it's an urgent situation, emergent

5 situation, and you feel you can't wait for

6 a prior authorization, you can go ahead and

7 do the treatment and send us a post-review,

8 you know, with the same information

9 required for the prior auth so we can

10 adjudicate it.

11 DR. BOBROWSKI: Okay. Well, thank you-all.

12 That's -- you know, when you just --

13 because this was a new code that was added

14 in recently. I think this was updated on

15 March 28th, I believe, of this year, and I

16 noticed that prior authorization required,

17 so, you know, that's a good point. I

18 appreciate you-all working on that with the

19 dentists and helping our patients just, you

20 know, get some treatment. And you dentists

21 know what ANUG is, acute necrotizing

22 ulcerative gingivitis, and you just hope

23 you never get that in your mouth.

24 And we just received today the -- and,

25 Erin, thank you for you and your team to --

1 they got us these dental codes. And I'm
2 sure probably the TAC members haven't had a
3 chance to look at those fully yet. But we
4 appreciate your all's work on getting that
5 together. And we may comment on that after
6 we have had time to review them. But does
7 any TAC Member have any comments on that so
8 far, or the prior authorizations, or
9 anything like that?

10 Okay. Then I know I'm talking about
11 rules and sometimes generalities, but if a
12 full mouth X-ray series is done within a
13 year we are not really going to get paid if
14 we have to do another X-ray, you know, if
15 they got a new trauma or new toothache. But
16 it says we can get a PA when we use the
17 D0140 code. Is that correct? Would we get
18 paid for that PA even though the other rule
19 says that once you get a full mouth X-ray
20 series, we are not paying for any more
21 X-rays for a year. So is anybody from DMS
22 that can answer that one?

23 MS. MADRAS: This is Ashley again. I'm not
24 sure on that. That one, again, I'll have
25 to take back to management and we will have

1 to research that one as well.

2 DR. BOBROWSKI: Okay. That's fine, and
3 thank you.

4 I tell you sometimes folks will come
5 in, we'll do our exam, cleaning, they come
6 in, they got a mouth full of old fillings,
7 big fillings, and, you know, three months
8 later they come in with a swelling, and, I
9 mean, you just have to get an X-ray. But my
10 point in all of this is, is that I think we
11 get \$7.25, so, I mean, it's not like that we
12 are -- \$10.00 for the first X-ray and 7.50
13 for the second.

14 But dentistry is -- and I'll explain
15 this as we go through today. We're just
16 getting hammered with the high costs. Our
17 supplies have just gone out the roof. And
18 I'll talk a little bit more about this after
19 while, but a lot of folks are having
20 staffing issues. And sometimes it just
21 feels like that we are getting nickeled and
22 dined to death and Medicaid practices are
23 really struggling, you know, to make ends
24 meet.

25 Okay. Let's move -- is there any

1 other Old Business? Any TAC Members
2 remember any Old Business that we need to
3 bring up?

4 MS. ROEHRIG: Dr. Bobrowski, this is
5 Rachael Roehrig with DMS. I put something
6 in the chat, but I wasn't sure if you were
7 able to see it. For the Old Business item
8 on the follow-up questions, we had sent
9 previously the top 15 used dental
10 procedures and codes based on paid amounts
11 and based on utilization. So we have those
12 already, but we would be happy to do
13 another data request to get that specific
14 utilization report for the second one on
15 the adult root planning. So we can take
16 that back and get that information.

17 If you wouldn't mind to send Erin the
18 exact codes that you want pulled, then that
19 will just make it a lot easier, if possible.

20 DR. BOBROWSKI: I'm making a note right
21 now. Yes, thank you. Yeah, that root
22 planing and there's those other things.
23 I'll try to get you -- I made myself a note
24 to send those codes. Make a note here.

25 Okay. And we appreciate the research

1 that you-all do to help us figure out
2 things. It kind of helps in planning or
3 helps the TAC maybe make some suggestions
4 and just helping providers give care.

5 Now, is there any other Old Business?

6 DR. CAUDILL: Garth?

7 DR. BOBROWSKI: Yes.

8 DR. CAUDILL: On your previous question
9 about X-rays I put something in the chat
10 that we go back from the KAR Regulations
11 that shows that even if you've taken a full
12 mouth series, if you need to take
13 additional ones later on for a root canal
14 or oral surgery, or you can show medical
15 necessity like something got broke along
16 the way, absolutely we can cover those.

17 DR. BOBROWSKI: Okay.

18 DR. CAUDILL: It's in the chat now.

19 DR. BOBROWSKI: Okay.

20 MS. MEDINA: And that is pretty much true,
21 Dr. Bobrowski, I think for all codes,
22 right, if there's a certain limitation or
23 guide, that's usually the general rule of
24 thumb, that, you know, if something is
25 medically necessary, for the most part we

1 have to factor that in, and there's always
2 exceptions, you know, going above
3 limitations or outside of age ranges, and
4 whatnot, to accommodate those type of
5 situations.

6 DR. BOBROWSKI: Okay. Because that was
7 kind of what -- I don't think I wrote it on
8 the agenda, but I made a note to myself
9 here that, you know, a lot of times we've
10 got to show diagnostic -- the X-rays are
11 for diagnostic purposes and for proof of
12 medical necessity. And I believe that's
13 what you-all are talking about is, like,
14 well, yeah, sometimes you just got to get
15 another picture and, you know, to help you
16 make your diagnosis or to see if -- so many
17 of these folks got such large fillings
18 that, well, you don't know, well, is it
19 this tooth or the one beside it, because
20 sometimes the swollen bump is right in the
21 middle of two of them. So that's why we do
22 need X-rays. But, okay, thank you so much.

23 All right. We are going to move on to
24 New Business.

25 DR. PETREY: Garth, I'm sorry, just clarify

1 one thing on X-rays.

2 DR. BOBROWSKI: Yes.

3 MR. MATTINGLY: And it's a horse that's

4 been -- that's been beat to death years

5 ago, but I continue to get questions about

6 from an orthodontics perspective. I

7 have -- we have worked under the

8 understanding that we are -- the Panorex

9 taken in the initial exam is inside of our

10 records. Any Panorex taken after that,

11 though, are -- we cannot and do not bill

12 for those. Is that still the

13 understanding? We -- obviously, we take

14 radiographs throughout treatment of active

15 canines, evaluating wisdom teeth, and more

16 specifically evaluating root resorption.

17 But the single initial exam X-ray is really

18 the only one that -- until our final

19 records that is -- whether they are taken

20 or not, that is a covered service. Is that

21 correct still?

22 DR. BOBROWSKI: That's the way I understand

23 it, Joe, is that you take that initial

24 X-ray, like that Panorex, and that's your

25 one for two years. Now, I think even

1 though you may have a Panorex, the way I
2 read the scripture is that within 12 months
3 if you needed to take a PA, you know, like
4 where you're moving the canine down, now
5 they would still cover for the PA. Now,
6 can any of the MCOs or DMS respond to that
7 and how that's handled on your end?

8 DR. PETREY: I know Jerry was part of
9 helping us figure this out years ago,
10 because the number of orthodontists that
11 had recoupments on X-rays that had been
12 billed for. But I still continue to get
13 the question of patients that are in
14 retention, that are no longer in treatment
15 that have radiographs by an orthodontist,
16 we are under the understanding that we
17 are -- that is a non-billable service or
18 should not be billed by the orthodontist.

19 In our practice we don't do it anyway
20 because we don't want to use the patient's
21 benefit that might be needed in a general
22 practice, but it is a -- it's a sticking
23 question with a number of practices.

24 DR. CAUDILL: Joe, if I can kind of go back
25 to those years ago when we were working on

1 this with Dr. Rich, who is the dental
2 director at DMS. It was kind of like
3 working linked radiographs on root canals.
4 They said, well, that's part of doing the
5 treatment, and they considered anything
6 during the treatment to be I can inclusive.
7 However, I don't personally remember saying
8 that two years or three years later you
9 couldn't take a Panorex.

10 DR. BOBROWSKI: That's kind of what I was
11 looking at.

12 DR. PETREY: I'll pass that along -- I was
13 just going to say, I'll pass that along. I
14 just -- we still just take them and don't
15 bill, and I think that's how we will
16 continue to do so, but I -- I know that
17 there are -- that's been a sticking point.
18 So thank you for that clarification.

19 DR. CAUDILL: And if anybody has a problem,
20 you know my phone number.

21 DR. BOBROWSKI: Okay. Thank you-all. We
22 are going to move to New Business. And I
23 just want to thank the folks that have --
24 the TAC and MAC. They have a member
25 orientation packet that they have produced,

1 and I really don't know exactly who to
2 thank for that, but I think that's a -- I
3 don't know who worked on it, but that's a
4 great idea to work on, and that way as we
5 get new members, we are -- the KDA,
6 Kentucky Dental Association, is working on
7 a replacement for Dr. Phil Shuler. So
8 hopefully when we get that person selected,
9 we can get them one of these orientation
10 packets and that will kind of help bring
11 them up to speed.

12 But does anybody from DMS want to
13 comment on those orientation packets?
14 MS. BICKERS: Dr. Bobrowski, this is Erin.
15 That was all Kelli. I glanced at it, made
16 a few recommendations, but she put a lot of
17 work into that, and that was a
18 recommendation, excuse me, from the
19 Consumer Rights TAC.

20 DR. BOBROWSKI: Well, thank you, Kelly, for
21 putting all that together. I think that
22 will be a great addition to getting folks
23 on board and up to speed.

24 MS. BICKERS: I will pass that along to
25 her. She's on the beach this week.

1 DR. BOBROWSKI: Oh, that lucky little girl,
2 I tell you what.

3 The second item under New Business is
4 the dental codes were updated on March the
5 28th. And I just wanted to put a thank you
6 in there that glad to see these additional
7 codes to treat gum disease, and that way us
8 general dentists and stuff, we are not
9 accused of supervised neglect. But, you
10 know, sometimes we tell patients, well,
11 that's just not covered, you know, you will
12 have to cover it yourself if you want it
13 done, and I guess that's -- you know, what
14 we've always told them. But now we are glad
15 to see that some of these other codes are
16 being added in.

17 Now, and I just listed the main five
18 there that were added in. But I did have a
19 couple questions on some of those. The
20 D3120, it's called an indirect pulp cap.
21 Now, again, it has a prior authorization
22 required, and my question is why, because
23 usually we don't know if it's going to
24 really get close to the nerve or not. Yes,
25 sometimes we can see our X-rays and we can

1 say, yeah, that's a big one, but sometimes
2 it doesn't require an indirect pulp cap.
3 But do you know why they added the words
4 preauthorization required? And I guess I'll
5 direct this to DMS.

6 MS. MADRAS: Hi, this is Ashley again.

7 That was the directive given to me when we
8 added the code to have a prior

9 authorization, but that is something,

10 again, that I can take back to management.

11 And if you can send us, you know, just,

12 again, a specific example of how that code

13 would be used and, you know, reasons why we

14 wouldn't need the prior authorization on

15 it, that would probably help us as well.

16 DR. BOBROWSKI: Okay. So noted. Got it.

17 Now, another question on that same
18 code is, like, why is there such a disparity
19 in the fee ranges? Because, I mean, I'm
20 glad to see the fee on there, because some
21 of the things -- a lot of the things we do
22 are so low that it's harder to recruit, you
23 know, some of the younger dentists to accept
24 Medicaid. But the -- kind of the cousin
25 code to that is the D3100, is for a direct

1 pulp cap, which pays \$17.00. And a direct
2 pulp cap means if, you know, you are
3 cleaning out a cavity and, boy, that cavity
4 just barely nicks that nerve, that they may
5 have not been in a lot of pain yet, but the
6 cavity was that deep, and we can put some --
7 a medicated treatment on that and then put
8 our filling in. But I was just wondering
9 why there's such a fee disparity. So I'll
10 add that into my notes, Ashley.

11 MS. MADRAS: Yeah. I will tell you some of
12 those codes we had problems finding other
13 states that paid for a lot of these codes,
14 so we had to look at private insurance
15 companies to get prices as well to get the
16 average. So that could very well be
17 affecting the price as well.

18 DR. BOBROWSKI: Okay. Well, and then see
19 that was another thing, that since you have
20 added the -- and I'll try to write all this
21 up, but I may not get it done this weekend
22 because I've got to mow my yard this
23 weekend and let it dry up so I won't get
24 mired up in the mud.

25 But anyway, the other one, question I

1 had on that was the D3100 is listed, and
2 it's always been listed for children only.
3 But since the indirect pulp cap was listed
4 for children and adults, that maybe we could
5 get that changed for -- to add the adults on
6 the D3100 code, just to make it uniform
7 across the board to just help us, you know,
8 treat our patients.

9 The other code was the D4346, was the
10 scaling in the presence of inflammation, and
11 that's all I'll send -- I think the question
12 on that one was -- we talked about that one
13 a minute ago about the prior authorization.
14 I'll make a note.

15 DR. CAUDILL: Hey, Garth.

16 DR. BOBROWSKI: Yes, sir.

17 DR. CAUDILL: Was your question that you
18 wanted the 3110 -- 3110 covered for adults
19 also?

20 DR. BOBROWSKI: For adults covered, yes.

21 DR. CAUDILL: Right, 3110. Okay.

22 DR. BOBROWSKI: Yes. Yeah. Those are
23 things that -- I mean, they don't happen on
24 every patient we treat, but it happens
25 often enough that, boy, sometimes if you

1 could just treat it -- and I know I've told
2 you-all before, I know I've got some -- at
3 least two groups of patients in our area
4 that are traumatic brain injury patients,
5 and I know there's just no way they can
6 come up with the cash to pay for some of
7 these treatments, and I was just trying to
8 get a more uniform across the board.

9 Now, the -- and then this is one that
10 I think we had talked before about, the 6110
11 and 6111, the implant supported dentures. I
12 think that's good to add that. The non IV
13 conscious sedation, just having your
14 anesthesia permit required. But I did have
15 one other one, and I forgot to put that on
16 our list, was the D0180, and which is a
17 periodontal exam, and those do -- they take
18 a lot of time to do them, I think, and do
19 them correct, chart recession, gum pockets.
20 But in the DMS website it does not show any
21 criteria on how to properly bill for that.
22 I know I personally have billed for it a
23 couple of times and it did not get paid. So
24 I was just wondering, well, what criteria do
25 we use to get that done, so I'll -- Ashley,

1 I'll try to send that one in also. That way
2 that can be looked at.

3 Dental TAC Members, are there any
4 other questions or comments on any of those
5 new codes? Hearing none -- and, again, this
6 will go -- this question will go to the --
7 to DMS and to the MCOs.

8 Of course, most everybody is aware of
9 the Change Health computer hack, and now
10 correct me if I'm wrong, but I had heard
11 that they got hacked a second time and that
12 I think they wound up paying right around
13 22 million dollars to get their stuff back
14 or access back to their records, and my
15 question was how has this affected the fee
16 for service and MCO payments and EOBs. And
17 I made a note that if each MCO wants to give
18 a response back to us, because this is
19 really affecting the dental offices. If
20 want to start with DentaQuest, if you want
21 to comment, or if you don't, that's okay.
22 But if you don't want to say anything right
23 now, just say pass, and we will go on to
24 another one.

25 MS. MEDINA: So on -- I think from our

1 perspective we haven't really seen any type
2 of delays, you know. We -- particularly --
3 now that's not to say the providers aren't
4 impacted. They go through different
5 clearinghouses before they come to us. So
6 I think the delay is happening before it
7 reaches kind of our organization. So we
8 have been able to kind of process
9 everything timely and within our normal
10 cadence.

11 Now, understanding that, you know,
12 there was a lot of kind of, you know,
13 challenges put forth for, you know, across
14 the country. We did put out some education
15 materials on some resources possibly, you
16 know, for providers to be able to submit
17 directly through us, you know, as an
18 end-term solution until some of those things
19 got cleared up.

20 DR. BOBROWSKI: Okay. And Passport?

21 MS. MARCUM: Hello, this is Becky with
22 Passport. Just a high overview. Molina
23 responded swiftly to CHC incident to limit
24 the impact to the provider community. The
25 clearinghouse options -- providers

1 utilizing CHC can submit claims to Molina
2 prior to the outage may now do so alternate
3 establish connections with the SSI
4 Claimsnet LLC Clearinghouse or another
5 clearinghouse of their choice. The
6 provider portal, which is Availity
7 Assistance Provider Portal Solution was not
8 impacted by this outage and remains
9 available as another option for the claim
10 submissions. The provider payments --
11 Molina has established a direct connection
12 with ECHO, a CHC partner, to resume
13 provider payments for processing. ECHO has
14 not been impacted by this outage. Payments
15 have resumed and will be processed in the
16 order it was received.

17 DR. BOBROWSKI: Okay. Thank you-all.

18 United Healthcare?

19 DR. RICH: Dr. Bobrowski, I show
20 alternative methods of payments either
21 using the portal or other exchange systems
22 were used in the meantime by many
23 providers. It didn't affect our system
24 directly. Obviously, it depends on which
25 exchange the provider was using at the

1 time. But everything is back online. I
2 don't know the exact amount of money that
3 was spent on resolving the problem, but the
4 information that you presented earlier, I'm
5 fairly certain was not correct being the --
6 about the 22 million. But I will tell you
7 that United Healthcare spent over a billion
8 dollars reestablishing the system and
9 putting it back together, and then also put
10 out more than three billion in loans to
11 providers to help them stand between the --
12 while the service was down.

13 DR. BOBROWSKI: Okay. Thank you.

14 WellCare?

15 DR. OWEN: Good afternoon, Dr. Bobrowski.
16 This is Stuart Owen. So, first of all,
17 paper payments and virtual credit card not
18 affected at all. Certainly to what others
19 have said, we tried to help providers use
20 other clearinghouses and platforms. A key
21 one that we connected folks with was
22 Availity. And so we had assistance to
23 expedite providers to be able to enroll
24 with Availity to use that platform. That's
25 what we tried to steer people to.

1 DR. BOBROWSKI: Okay. Thank you, Stuart.
2 MR. OWEN: Sure.
3 DR. BOBROWSKI: Humana?
4 MS. GRAY: Hi, this is Kim Gray with
5 Avesis. I can speak on behalf of Humana
6 and Aetna. So Avesis did act swiftly to
7 the CHC incidents that occurred at the end
8 of February. We are accepting claims via
9 paper, as well as through various
10 clearinghouses including DentalXchange or
11 Vyne for electronic claims submission, and
12 we also accept claims through -- directly
13 through our portal. We are currently
14 making payment via paper and EFT, and EOBs
15 are available for download on our portal.
16 Notification did go out to the provider
17 community at the end of February, around
18 the February 26 time period.
19 DR. BOBROWSKI: Okay. I want to thank you.
20 Any TAC Members have questions or
21 comments?
22 I know some of those -- let me make
23 one more note. So a lot of those we can go
24 to the portals. I've had some dentists say,
25 well, they were afraid to, you know, get

1 some treatments started on, you know, root
2 canals or dentures or something, because
3 they just -- we were having so much trouble
4 getting -- either getting paid, or if they
5 did get a check, it's like, well, which
6 accounts do these go on, or did they deny
7 payment. That would probably be the worst
8 scenario, if did go ahead and do treatment
9 and for some reason it didn't get covered.
10 So thank you-all for those comments. It
11 looks like everybody is on top of that.

12 And I've got another question, and I
13 guess this will -- well, this will be for
14 DMS or for the MCOs. Now, this one happened
15 to me. I had a lady, you know, come in for
16 new dentures, and I think she had had some
17 immediates several years ago or something
18 and now has Medicaid, but she understands
19 that, you know, the Medicaid dentures are
20 not the -- you know, I guess you'd call it
21 the premium dentures. But anyway, she asked
22 me about it. She said, I would like to get
23 a premium style denture and she offered to
24 pay the difference between, you know, what
25 Medicaid pays and what the premium denture

1 is. Now, since it involves a payment, I
2 know Medicaid has a form that for anything
3 that is not covered by Medicaid or like this
4 difference here, they sign it that they
5 agree to this price, and we -- we just go.
6 We do it.

7 Now, I told her, well, I don't know
8 really what Medicaid will do on this. The
9 first time we have ever really had anybody
10 ask. But I'll tell you, I know one of the
11 labs we use, they told me, said, now,
12 Dr. Garth, we are not going to -- some of
13 these cheap dentures -- even the lab said we
14 are not going to do those because they don't
15 want their name on it. And it's the same
16 thing. I mean, it's just the -- on some
17 items of the expansion codes that the
18 payment is -- is quite a bit less than what
19 a -- like a premium denture would be. I'll
20 use that as an example again. But our lab
21 said -- or one of the ones we use, he said
22 I'm just not going to go there with that
23 style denture.

24 So then sometimes you're trying to do
25 these treatments and it gets to really

1 sometimes your labs are limited on -- you
2 got to go hunting a lab that will do these
3 4A -- or I guess sometimes we just say,
4 well, you've got to go to one of those
5 places that's a denture mill and you go in
6 at 8:00 in the morning and you come out at
7 4:00 and you get your dentures. And then
8 those denture patients come to me and they
9 say now what can we do, because they are
10 just so cheaply made that they are just not
11 holding up.

12 But can anybody from MCO standpoint or
13 from DMS standpoint, can you help give us
14 some guidance on that?

15 MS. BICKERS: Dr. Bobrowski, I'll take that
16 back to the policy department.

17 DR. BOBROWSKI: Okay.

18 MR. OWEN: I was going to say -- this is
19 Stuart with WellCare. I mean, generally if
20 something's not covered by Medicaid, then
21 the member basically has to give written
22 consent to the provider that they agree to
23 pay for it if it's not covered. This is a
24 little bit of a gray area.

25 DR. BOBROWSKI: Right.

1 MR. OWEN: The denture is covered, but she
2 wants a better one.
3 DR. BOBROWSKI: Right.
4 DR. CAUDILL: It's usually an aesthetics
5 thing. They want the more natural-looking
6 teeth. So it's more aesthetics is what it
7 is.
8 DR. BOBROWSKI: Well, and then the other
9 thing is it's like the quality of the
10 actual teeth that go in the denture, the
11 cheap ones they just -- it's just like
12 buying a 29.95 tire versus a \$99.00 tire.
13 The \$99.00 ones typically last longer. So
14 by using a better quality teeth, those
15 patients are going to get a little --
16 hopefully going to get a little
17 longer-lasting denture, because they wear
18 down, they get so flat they are just
19 mashing their food, not chewing their food.
20 So that was kind of another, I guess, a
21 point of information on those that just the
22 quality of the dentures -- but I'll send
23 that to DMS there and...
24 DR. RICH: Hey, Garth, this is Dr. Rich. I
25 think the problem that we are running into

1 here is the fee is not -- you know, the fee
2 is what it is, right. And the code is what
3 it is. There is only one denture code.
4 There's an upper denture code and a lower
5 denture code. There's not a premium
6 denture code and a mid-level denture code
7 and a low denture code. There's one
8 denture code and there's one fee associated
9 with it. If it's a commercial insurance,
10 they pay one fee. You can't -- you don't
11 get to change your fee depending on what
12 kind of denture the patient wants. Your
13 fee is the same. And I totally understand
14 and appreciate what you're saying. You
15 know, it's like, hey, we want to make
16 better dentures for these people, but we
17 can't afford to. They would like to pay
18 for a better denture. You can't afford to.
19 You can't make the procedure dependent on
20 the patient paying partial, part of the --
21 that's not the way Medicaid works, you
22 know. And that's the place we are stuck in
23 here. And so I totally appreciate and I
24 know you are trying to do the best for the
25 patient and everything else, but I think we

1 ought to come up with a way to resolve --
2 the initial problem is how do we address
3 the fee itself and what do we want -- what
4 does Medicaid want to provide for the
5 patient. If this is the denture that we
6 are seeing everybody in the state gets,
7 that's the one you get and I don't think
8 there's another choice, you know. It's
9 like that's what the state said they are
10 going to cover. That's what they cover.
11 If you want something else, that's on you.
12 This is what -- I don't know. You know,
13 there's a lot -- there's a lot of, you
14 know, opinions and thoughts on this, but
15 really in the end it's one code, it's one
16 fee, and if you get down to the black and
17 white, you know, you can't charge -- you
18 know, just because you want to shine the
19 amalgam more, you can't say, hey, I'm going
20 to make this one extra shiny if you'd like
21 it, but it's going to cost you another 20
22 bucks. You can't do that. So it's the
23 same thing with -- you know, you got to
24 have the same rules, everything, or it
25 doesn't work out.

1 So, you know, like I said, I totally
2 appreciate it, but until we -- we got to fix
3 it universally. We can't do this piecemeal
4 thing together. And I think we are all
5 going to stumble until we figure out a way
6 to come up with a universal fix. And
7 partial payments, or making one procedure
8 that's not covered required for a patient to
9 have a procedure that is covered, that
10 doesn't work either. You know, that's not
11 the way Medicaid is designed to work. So, I
12 don't know, I'm with you on this, and you --
13 we want a solution that works for the
14 patient. It's not just a service that's
15 there that's not functional or really
16 doesn't benefit the patient, because we are
17 spinning our wheels. So, you know, but I
18 think we need to address the fact that
19 there's just one denture code, and no matter
20 how you do it, you know, if you work with an
21 insurance company or if you work with
22 Medicaid or if you work with Medicare, one
23 fee is assigned to that code and you can't
24 balance bill. That's just always been, I
25 know -- unless CMS changes the rules, you

1 are not going to be able to balance bill.
2 Enough of me rambling, but thank you.
3 DR. BOBROWSKI: But, see, that's what I
4 mean, that's a good point, you know,
5 because there is one fee and typically that
6 fee that Medicaid covers is really not a
7 fee for, you know, IPM teeth and, you know,
8 the best teeth out there. You know, some
9 of those IPM teeth are, you know, a little
10 bit less than what the whole thing that
11 Medicaid covers on those. But that's a
12 good point, too. So, anyway, we'll send it
13 back to the policy department.

14 But I told that lady, really, that's
15 probably about the first time I've had that
16 asked to me, but it was one of my patients,
17 and I said, well, I'll just ask at our next
18 meeting and see what they say on it. So
19 I'll get this sent to you-all quickly here.

20 Now, here's where my typo was on
21 that -- the previous agenda I sent out.
22 It's the PIP Program, or Performance
23 Improvement Project, for children's dental
24 visits, topical fluoride, sealants. And I
25 wanted to put that on the agenda today

1 because it's so new for us the TAC Members,
2 that all this is just -- is just brand new
3 for us, and I wanted to make sure that the
4 TAC Members knew what was going on with
5 this.

6 Let me see. I've got some
7 information, but -- and we probably don't
8 have to spend a lot of time on this, but
9 just wanted to -- it's a state I-Prof Focus
10 Study on children's oral health, and it's
11 called the Performance Improvement Project,
12 PIP, and it's going to be for the years '24
13 and '25, so it's a two-year project. It
14 comes through the Quality of Care Department
15 that reaches out and works with the MCOs,
16 kind of looking at increasing the rates of
17 topical fluoride application for children
18 ages one to four, using the dental code
19 D1206, or the physicians code, and an oral
20 evaluation, dental services for under age
21 21, and for sealants for the age group of
22 six to nine, dental sealants for the age
23 group of 10 to 14.

24 But I believe, and somebody correct me
25 if I'm wrong. I can look it up here, too.

1 But I was believing that as long as they are
2 20 and under, we could still apply sealants
3 to the children or teenagers' teeth. Now,
4 there's another section of this, is that
5 there's a dental provider access on focus
6 counties from the focus study, and it
7 listed, oh, about four or five counties in
8 Kentucky that just had limited provider
9 access, and that there may be other counties
10 out there that have a disparity in provider
11 access. And some of this was related to a
12 provider within 50 miles of the member's
13 county. And they are going to use this to
14 educate primary care physicians and their
15 staff on how to apply fluoride varnish in
16 the medical setting, but I wanted to bring
17 that up so that other TAC Members -- TAC
18 Members, I'm just kind of getting
19 information on this just recently, and I
20 know we haven't had a chance to talk about
21 it, but I wanted to start letting you-all
22 know about it, that the MCOs are working on
23 this. And, again, part of this is just to,
24 you know, try to move the needle into better
25 oral health for our Kentucky patients.

1 Now, any TAC Member got any questions
2 so far?

3 DR. PETREY: I just want to say thank for
4 sending the link there. That's helpful.
5 Thank you.

6 DR. McKEE: Dr. Bobrowski, it's Julie
7 McKee.

8 DR. BOBROWSKI: Yes, Dr. Julie.

9 DR. McKEE: I just have a couple of
10 comments here. I've been working with
11 these people on trying to get these
12 projects off the ground and I appreciate
13 their inclusion for me. The sealants --
14 the targeted sealants six to nine and 10 to
15 14, those are actually national standards
16 that we can benchmark ourselves with. Yes,
17 you can put sealants on any kid at any time
18 until they age out of Medicaid as a
19 pediatric patient. But we really try to
20 work with providers to get those sealants
21 on when the teeth are erupting at those
22 ages, so that's why they are kind of
23 divided up.

24 DR. BOBROWSKI: Okay.

25 DR. McKEE: Now, we are not doing a real

1 good job of it, thus the Performance
2 Project, because according to more recent
3 Medicaid data for Kentucky, that these
4 children at the optimum ages of six to
5 nine, 10 to 14, only between 11 and
6 13 percent of any eligible patient is
7 getting one sealant, and it could -- it
8 should be more than that and that's what
9 they are trying to do. Also, I really
10 commend them trying to reach out to the
11 primary care medical community for oral
12 assessments or screenings and varnish
13 application. They can -- I've offered to
14 train their physicians, and I've got a
15 presentation; I can do that at any time.
16 But they can also provide to their
17 providers an online course called Smiles
18 For Life. And what that does is that
19 teaches non-dental health professionals how
20 to do an oral assessment, why to do it, how
21 to do varnishes effectively, and why to do
22 them. And that should train them enough to
23 apply the varnish for billing. So it's
24 pretty good. And the thing is, is the
25 provider can do that at their own leisure,

1 the training.

2 DR. BOBROWSKI: I'm making a couple notes
3 there. Well, yes, and thank you,
4 Dr. McKee, on that.

5 I got a couple of things, and TAC
6 Members please chime in with some ideas or
7 if you think of something, you know, later
8 on or over the weekend or next week, just
9 either get them to me and I'll forward them
10 on to DMS, or you can send them yourself.

11 But, Dr. McKee, have the focus groups
12 reached out to maybe -- I know it said the
13 primary care physicians' offices and their
14 staff, but what about also the public health
15 departments?

16 DR. McKEE: The public health
17 departments -- excuse me. I think I must
18 have been talking all week because it's
19 Friday afternoon and my voice is finally
20 wearing down.

21 The public health departments do tens
22 of thousands of varnishes a year with their
23 clinical patients. Now, they have decreased
24 over the years for a couple of reasons, and
25 one of them is because of the swing of the

1 pendulum, and that's a whole another hour
2 lecture. But our public health departments
3 are doing less and less hands-on clinical
4 procedures for patients in a clinic. It's
5 become more population based, so we are not
6 seeing even the opportunity to do the
7 varnish, so it is decreasing. But I train
8 nurses all the time and it still happens,
9 but it is decreasing. Once -- and I say a
10 pendulum, because one day soon, not in my
11 professional lifetime, it will swing back
12 where health departments will see patients
13 for clinical care such as well-child
14 examinations, immunizations, family
15 planning, things like that, the hands-on
16 clinicals that they can do. We tried to
17 incorporate varnish into the WIC visit and
18 the HANDS visit, and their curriculums are
19 so tight right now they don't allow that.
20 But we are going to try again soon for that.

21 Health departments are doing what they
22 are interested in doing. For a varnish just
23 one more hour-long lecture is not considered
24 a core function in health departments. It's
25 optional. Now, is it optional to Julie

1 McKee? Blankety-blank, no. It should be
2 mandatory. But it's an optional thing. A
3 lot of health departments coming out of
4 Covid have rethought and they have paired
5 down to what they either have to do
6 according to the law and what they get paid
7 enough to do, and they don't get paid enough
8 to do the varnish.

9 DR. BOBROWSKI: Okay, yeah. Because I
10 know -- I'm on our local health board, and
11 I know, you know, year by year -- I mean,
12 financially, you know, we are okay, but,
13 boy, sometimes you hope the refrigerator or
14 the air conditioner doesn't go out, you
15 know. Sometimes it just runs pretty close.
16 And I told one of the ladies, one of the
17 nurses over at our health department, I
18 said, well, listen, whenever you want to
19 get that one room painted, I said, call me
20 and I will come over and help you move the
21 furniture and help you get that room
22 painted, because for some reason it was
23 painted years ago -- it was painted some
24 kind of brown, and just didn't look very
25 good in a health department. So anyway, I

1 told her to call me, we'll get this thing
2 painted and done for you.

3 But, you know, one of the things that
4 we do at our office is -- well, two things
5 for the -- usually for the one to four or
6 five-year-old group, we just call them a fun
7 visit. And we'll tell the parents to bring
8 them in, let us, you know -- you know, just
9 have some fun with the kids. I know one of
10 our daycares here in our county, usually
11 once a year they will bring 30 or 40 kids
12 over. You know, nothing gets billed. We
13 just bring them in and have fun. We just
14 ride them up and down in the chair.
15 Sometimes we will get five or six in one
16 chair. We will -- we kind of squirt water
17 on their hands and then get the little
18 Mr. Slurpy, you know, and let it suck the
19 water out of their hands, so that they start
20 to get used to the noises and the equipment,
21 and let them know that this is not totally
22 dangerous stuff. But we just call it a fun
23 visit.

24 And then another thing we do is we
25 tell the parents, well, go home and just,

1 you know, like kids like to play doctor or
2 they like -- I said, well, play dentist. I
3 say get the flashlight out and get a spoon.
4 Kids are used to putting a spoon in their
5 mouth. You know, just let the spoon be your
6 mirror, and just tell the kids, well, we are
7 going to play dentist and the dentist is
8 going to count your teeth, and you help me
9 count them. We are going to look at them
10 and shine a flashlight in there, because
11 that's the term we use when they come in.
12 So I don't know -- those are -- each office
13 has got their way own way of handling little
14 ones, but I think you got to try to make
15 those first visits, you know, fun and
16 enjoyable and educational. And, of course,
17 from those days all the kids, they get to go
18 get in the prize box, you know, and pick out
19 a prize.

20 But any TAC Members got any questions
21 so far on the Performance Improvement
22 Project?

23 Okay. Let's see, let me get my other
24 page here. I wanted to get a couple of
25 things just out for DMS and the MCOs. This

1 comes from the USA Today, Becker's Dental
2 Health Review and the New York Times and the
3 AGD News. These are just some tidbits.
4 Wal-Mart is closing health centers in 51
5 locations in five states along with their
6 telehealth program, and the reason why is
7 just escalating operational costs and
8 challenging reimbursement environment, is
9 the terms that they used. They are not
10 closing the pharmacies or the vision
11 centers.

12 Now, some states we are doing kind of
13 a hybrid of, you know, telehealth and hybrid
14 care. And one other tidbit was they were
15 talking about, like, for folks with total
16 hip arthroplasty -- this was a large
17 ten-year study on hip replacements, that
18 they were suggesting to wait one-year postop
19 before they have any invasive dental
20 treatment. And they also say to be sure to
21 take your preventive antibiotics or premeds.
22 But this is a thing that maybe as a TAC, and
23 maybe we could bring this up at the MAC,
24 that, you know, due to these recent studies,
25 that people that are anticipating, you know,

1 hip, knee replacements, things like that,
2 they may want to get a dental visit in and
3 just make sure that if they got any bad
4 teeth, either get them out or do a root
5 canal, or, you know, be aware of them. It's
6 just, you know, so that they don't have
7 complications while they're recuperating
8 from like a hip replacement.

9 And then another tidbit was the --
10 some of the independent pharmacies are
11 really struggling. Now, when they passed
12 the bill through the Kentucky legislature
13 that limited it to one PBM, they commented
14 that, well, this has helped them, but,
15 again, their low reimbursements are making
16 their life challenging. And that just kind
17 of ties in with some of the things that
18 dentists are doing.

19 And I'll just give you an example out
20 of my office. Two years ago we had to
21 replace the whole suction system, and that
22 was listed at close to \$21,000. I had --
23 about a month and a half ago I had one X-ray
24 unit go down. That's going to be another
25 5,000 to fix that. About two weeks ago my

1 air compressor that runs the whole office is
2 going down. And when you live out in the
3 country, you know, you try to buy stuff
4 that's got two or three motors on it, and
5 the pressure that I had was -- did have
6 three motors on it. But these are air
7 compressors that you shouldn't go down to
8 Lowes or the hardware store and just buy a
9 regular air compressor. They usually don't
10 work as good and as well, and to provide
11 quality dental care. But these are
12 specialized air compressors where dental
13 offices -- but they -- I just got my quote
14 in this week and it's another \$20,000. So I
15 just want to let you -- it's expensive to
16 run a dental office and, yeah, there's money
17 that comes in, but when you got these kind
18 of expenses -- and these are pieces of
19 equipment that are, you know, 10, 12 years
20 old, and they are already having to be
21 replaced.

22 Now, let me see. Now, here's another
23 situation that a lot of offices are having,
24 and I'm going to put this down in our Other
25 New Business or our tidbit section, is

1 that -- this is coming from the ADA's Health
2 Policy Institute and McKinsey & Company, and
3 it just says the numbers are scary. The
4 34 percent of dental assistants are expected
5 to retire by 2028; 31 percent of dental
6 hygienists are expected to retire by 2028.
7 That's just four years away, folks. And
8 36,000 is the number of dental workers that
9 United States could be short by 2031. And
10 we definitely need to look at working on
11 things that we can do to help keep our
12 Medicaid, you know, doctors going.

13 This is just stuff I found out this
14 last two weeks, was that in Kentucky there's
15 a -- one of the pediatric offices that I
16 know about is no longer accepting any new
17 patients. Another one is stopping to see
18 their older teens. Let's see. And I guess
19 that's my point of bringing some of this up,
20 is that, you know, we need to keep working
21 on things that we can keep our doctors in
22 our Medicaid house, and even recruit new
23 doctors.

24 You know, in my county here -- I know
25 I don't look like it, but I'm going to be 71

1 this summer. I know I look like 41. But
2 anyway, the other dentists in our county
3 that takes Medicaid, I believe he is 68.
4 And the young ones that are in our county do
5 not accept Medicaid and can't get them to.
6 Part of that, you know, they say is low
7 reimbursements, the paperwork, the prior
8 authorizations, you know, cost of equipment,
9 cost of staff, and the staffing shortages.
10 The debt they got when they get out of
11 school, you know. So those are all things
12 that -- you know, they play it into the
13 factor. So as a Medicaid provider for 44
14 years, we have just got to keep looking at
15 things that we can do to help providers stay
16 an active provider in their counties.

17 But any TAC Members have any Other New
18 Business?

19 DR. BRAUN: This is Carol Braun. I just
20 have one question in particular. About a
21 week ago we received something from
22 Passport regarding prepayment review of
23 some procedures which would be instituted
24 as of June the 1st, and then they
25 underlined that this is not a prior

1 authorization, but it really sounds like
2 the steps are the same. So has anyone else
3 looked over that or have any concerns about
4 that?

5 DR. BOBROWSKI: Anyone from Passport or DMS
6 talk about this?

7 MS. BICKERS: I don't see Jennifer from
8 Program Integrity on, so I can take that
9 back to her and get you guys some
10 clarification.

11 MS. BRAUN: It's just concerning because it
12 sounds like, okay, prepayment review, it's
13 like you could submit it, they are not
14 going to pay you 'til they review it, which
15 to me is the same as prior authorization.
16 And as a pediatric dentist, the code for
17 stainless crown, D2930, is something that
18 we use really quite frequently. And the
19 other for everyone is on extractions.
20 Well, of course, you are going to have an
21 X-ray. Depending on the child, you may or
22 may not have an X-ray, but it is -- to me I
23 don't get the difference, so that was my
24 concern.

25 MS. BICKERS: I'll take that back. I was

1 typing it up. Sorry for the delayed
2 response.
3 DR. BRAUN: No. Thank you.
4 DR. BOBROWSKI: Erin, is that you?
5 MS. BICKERS: Yes, sir.
6 DR. BOBROWSKI: Okay. Sometimes I'm trying
7 to take notes so that I don't forget
8 something. But, Erin, I hope you are
9 taking notes, too, just to keep up. And I
10 do apologize, sometimes I'm so busy taking
11 my notes own notes again on this, sometimes
12 I don't get the things out of the chat.
13 I'll see it sitting there with the numbers
14 on there. I just haven't had time to write
15 on that.
16 That was another question. Is there a
17 way that these websites, some of them have
18 got a name on them two miles long. But is
19 there a way that I can get somebody from DMS
20 to just e-mail me those -- that information
21 out of the chat box?
22 MS. BICKERS: Yes, sir. We always add --
23 everything that I send, that meeting
24 information e-mail I send you after every
25 meeting, that always has all the chat

1 information included.

2 DR. BOBROWSKI: Great, great.

3 MS. BICKERS: Yeah. I always try to grab

4 all of that. That's why I'm also delayed

5 in responding sometimes, because I'm

6 grabbing chat information or --

7 DR. BOBROWSKI: Yes.

8 MS. BICKERS: -- constructing the DMS

9 follow-up e-mail that I also send.

10 DR. BOBROWSKI: All right. Dr. Braun, did

11 you have anything else?

12 MS. BRAUN: No. That's all. Thanks.

13 DR. BOBROWSKI: Or Joe? Okay, thank you.

14 DR. PETREY: Garth, I would comment on your

15 last statement about simply number of

16 providers. One situation that we are

17 beginning to see really in all of our

18 locations is pediatric dentists being

19 overrun and lowering the age at which they

20 will -- they will continue to treat --

21 DR. BOBROWSKI: Yes.

22 DR. PETREY: -- which I completely

23 understand. The issue is that in two of

24 the three areas we don't have providers to

25 take these what become new patients. In

1 essence, it's a patient who has had care,
2 but then can't find care because they
3 simply aged out of the pediatric dentist.
4 And as we are seeing them through this time
5 period while they are under orthodontic
6 care, or retention, we are having a major
7 struggle with dealing with patients with
8 active decay and simply just not being able
9 to even have a prophylaxis because they have
10 aged out of the pediatric dentist. And our
11 pediatric dentists are working with us, but
12 they have limits to what age that they are
13 able to do to continue to even function,
14 and we have this almost gap of patients
15 that are getting lost because they are
16 not -- older patients that have already
17 been in an active adult practice, or they
18 are -- they are new to the system because
19 they've essentially been dropped from the
20 provider that they had and don't have
21 anybody accepting new patients. It's very
22 challenging.

23 DR. BOBROWSKI: Yes, and thank you for
24 bringing that up, because that's exactly
25 right. And I know of another pediatric

1 office that they have done just that. They
2 have lowered their age down to, you know,
3 nine to 12-year-olds and under. So you got
4 that teenage group that's like where do we
5 go. And a lot of offices are not accepting
6 any new Medicaid patients. But it's
7 like -- and, Dr. Joe, it's like on these
8 fillings, like, they -- and I think DMS
9 needs to look at this seriously, is the fee
10 that we are getting paid for a filling.
11 Like a one-surface filling, I noticed that
12 was one on that list was one of the top 15
13 or top 30 codes that's used. And if we can
14 get those in and get them fixed, that one
15 surface filling will prevent a tooth loss
16 or an abscess or several hundred dollar
17 root canals, several hundred dollar crown,
18 so -- but DMS, I'm just encouraging you to
19 really look at the fee. I mean, you get
20 \$38 for an amalgam and \$44 for a white
21 filling. I mean, for a lot of offices, you
22 can't -- by the time you pay for your front
23 office staff, one person, you pay for an
24 assistant, \$34, you're already in the hole,
25 and that's what we are hearing a lot of

1 dentists complain about, well, I can't keep
2 working and we want to help people, but I
3 can't go in a hole, or else you don't have
4 any dentists at all.

5 DR. PETREY: I think, too, it's also --
6 there's an economic consideration to have
7 there as well, especially these patients
8 that are, in essence being dropped or lose
9 their dental home because they are aging
10 out. There's no doubt in my mind from an
11 economic perspective from what limited
12 funds and limited resources the state has,
13 when that patient is dropped that needs a
14 one-surface restoration and we -- we work
15 to get them into a new dental home, and
16 sometimes that can take six, nine months,
17 that may now turn into a root canal, which
18 we are talking about a root canal, a
19 multi-surface restoration, we are talking
20 about a crown. So the economics of it is
21 that that patient not only has not gotten
22 the care they deserved, but also from the
23 state's perspective, the cost to treat has
24 gone up significantly on that individual
25 because we were not able to get them into

1 care when they had a minimal treatment, the
2 single surface restoration.

3 I know that seems -- that seems like,
4 gosh, that happened on Thursday and that's
5 the only time. We are consistently seeing
6 that. And it's a -- and it is especially in
7 this age group of kids that are aging out of
8 the pediatric dentist and there just is not
9 anybody taking them. And the practices that
10 are taking them are so overrun, we are not
11 able to get them into the new dentist for
12 nine months, and that is -- and when they do
13 go they get a cleaning and then back another
14 three, six months to get the restoration.
15 By that time we have a major problem.

16 DR. BOBROWSKI: Yeah, yeah. And speaking
17 of the two things, the dental homes and the
18 mobile dental units, they do provide some
19 good service, but the problem that we see,
20 and another dentists across the state says
21 the same thing, it's just like, well, we
22 call the mobile unit that went to the
23 school system, and I understand that really
24 helps the parents get the kids checkups and
25 a cleaning. They will send a sheet home

1 that, well, your child has three cavities,
2 you need to go see your local dentist.
3 Well, then we try to get ahold of them to
4 -- well, which three teeth is it? So,
5 well, parents don't know. They weren't
6 told that. So then you say we've got to
7 have you in and do an exam. Well, that's
8 another fee. But I always thought that the
9 mobile units, if they find cavities and
10 have the opportunity to provide that
11 service, they are supposed to fix that
12 stuff. Well, then we call them -- they
13 don't do that, then we call them and say,
14 well, can we get the X-rays you took. No,
15 we can't get the X-rays. So that means we
16 got to take new X-rays. So that's a
17 situation that needs to be looked at too.

18 And the other thing, Dr. Joe, you
19 brought up about the dental homes, and this
20 is just an idea. You know, we -- we have
21 people every day just flat not show up for
22 their dental appointments. And the one guy
23 yesterday, I looked back in his chart and
24 he's missed six appointments. Now, how nice
25 am I supposed to be, you know, to let this

1 continue? And usually when folks miss --
2 and it doesn't matter if it's a Medicaid or
3 not Medicaid, but we try to ask them, well,
4 what happened, and we hope nothing bad
5 happened. And, you know, yesterday this
6 guy, the one that missed six appointments,
7 it's like, well, the last one he missed
8 is -- we actually made a note in there. We
9 got ahold of him and said, well, he just
10 didn't want to come that day. I mean,
11 that's just not acceptable behavior for them
12 not to even call or have the respect for
13 that dental office or their dental home.
14 And this was one of the -- this is an idea
15 that I had yesterday. I said, well, when
16 these homes are -- these dental homes are
17 being established, if there would be a way
18 or a form they could sign emphasizing these
19 failed appointments, or not to fail
20 appointments call the dental office, call
21 the clinic to let them know that you can't
22 come. That gives them a day or two of time
23 to get somebody else in.

24 But, you know, these dental homes just
25 when they are being set up for these

1 patients, say, look, this is the only
2 dentist we've got in 50 miles. If you don't
3 keep your appointments, you are going to
4 have to go 50 miles or more to get your
5 dental work done. I'm just -- and I know
6 some offices, you miss one, maybe two
7 appointments, they just dismiss you. But
8 anyway, I think this failed appointments
9 stuff has got to be addressed. That's
10 another big reason that Medicaid is losing
11 providers. But I'll not say any more about
12 that.

13 Now, one other question I had, and I
14 guess this is for DMS to look into, are the
15 MCOs being paid enough on their capitation
16 plans, I think is what you call it, to cover
17 their expansion codes on the adult dentures,
18 crowns, et cetera. I have no idea, but I
19 just want to be try to be fair to everybody
20 to make sure that, you know, we're viable
21 financially to do the things that we're
22 doing. And maybe that's a topic we can
23 bring up at the next meeting, but I just
24 wanted to put that out there just being fair
25 to everybody that works with Medicaid.

1 And, Dr. Joe, you talked about the
2 people not accepting patients. Yesterday I
3 had a 73-year-old lady, mentally retarded,
4 but she's cooperative, but she is hard for
5 me to get X-rays due to her movement. But
6 her dentist that she had been doing to for
7 years, I guess, had said, well, she took --
8 she quit taking this lady's Medicaid. But I
9 can understand why in a way. It took us 90
10 minutes for the hygienist, you know, just to
11 polish her teeth and, you know, get her, you
12 know, kind of up to par. Could not do a lot
13 of scaling, but we did -- we were able to
14 get some bite wings that show the tarter.
15 We got a periodontal exam done. And it also
16 took another assistant 30 minutes of time
17 just to go in there and help the hygienist
18 with her, you know, and we get paid \$60 or
19 \$61 and change.

20 So you can see there's just another
21 example, yeah, we want to help these people
22 because her other dentist, you know, quit
23 seeing her. And she's a non-verbal, you
24 know, patient other than grunts and noises
25 like that. But these -- these folks need

1 help, and I just wish we could do more, you
2 know, for them. But at the same time we've
3 got a small business to run, and like Joe
4 said a minute ago, that some of the offices
5 that do take the Medicaid, we just get
6 swamped. But anyway, we just got to keep
7 working on all this. We got to get some new
8 people helping with the Medicaid program in
9 terms of being providers.

10 That's all the New Business I got.
11 Any TAC Member got any other New Business?
12 Do the TAC Members feel like there's any
13 motions that we need to present to the MAC?
14 It sounds like a lot of these dealing with
15 these codes, I believe we can get a lot of
16 those questions to Erin and she'll be able
17 to spread the love and get some of these --
18 get some of these codes looked at. But any
19 other ideas from the TAC Members?

20 DR. PETREY: Not at this time.

21 DR. BOBROWSKI: Okay. Well, thank you-all.
22 And I wanted to remind everybody that there
23 is going to be another Medicaid forum this
24 fall in August, the 24th, at the Galt House
25 11:30 to 1:30 Eastern time. You know, last

1 year I thought we had a really good
2 turnout. We had a lot of good
3 conversations with providers. Commissioner
4 Lee was there, and we were glad that she
5 was able to be there and talk. And, you
6 know, we had representatives there from the
7 MCOs. And I just thought it was a really
8 good turnout. And we wanted to thank
9 Avesis for providing the luncheon, and I
10 believe they are going to do that again for
11 this year, and we do appreciate that and --
12 excuse me.

13 But our next meeting is going to be
14 August the 9th at 2:00 p.m. Eastern time.

15 Is there any other business to come
16 before the TAC meeting today?

17 MS. O'BRIEN: Dr. Bobrowski, this is Jean
18 from Anthem. I just want to ask a quick
19 question. For the KDA meeting, is it going
20 to be just a form? No presentations or
21 anything are needed for that; is that
22 correct?

23 DR. BOBROWSKI: Right. There's no
24 presentations from the MCOs. We do like to
25 have a representative from each one if we

1 can --

2 MS. O'BRIEN: Yes.

3 DR. BOBROWSKI: -- to answer questions.

4 And then I believe we are also going to

5 have a course presented by Dr. Caudill this

6 time on -- well, kind of on these handling

7 our special needs children, I believe is

8 maybe not the exact title, but -- and then

9 we are going to be including other MCOs as

10 we go. But we are going to -- we'll give

11 everybody ample time to have something

12 prepared, you know, when we do those going

13 in the future. But, yeah, you don't have

14 to have anything specifically prepared

15 other than bring your knowledge cap with

16 you, and I --

17 MS. O'BRIEN: Okay.

18 DR. BOBROWSKI: -- know you got plenty of

19 knowledge, Ms. Jean.

20 MS. O'BRIEN: You are so sweet.

21 No. I just I wanted to be sure. I

22 just wanted to ask so that we were prepared.

23 DR. BOBROWSKI: Yes.

24 MS. O'BRIEN: Thank you.

25 DR. BOBROWSKI: Yes. Thank you.

1 Well, I believe that's got everything
2 on my list. And I want to thank everybody
3 for hanging in there with us today. A lot
4 of -- a lot of stuff to look at and keep
5 working on, but we'll just keep working
6 together.

7 Anybody from DMS want to say anything
8 while we got a minute?

9 All right. Well, I will make a motion
10 we adjourn.

11 MS. BRAUN: I second that.

12 DR. BOBROWSKI: All right. Thank you.
13 Thank you-all. You-all have a great
14 weekend, and I hope you-all have a great
15 Mother's Day.

16 MS. BRAUN: Thank you so much.

17 DR. BOBROWSKI: Thank you. Bye, bye.

18 * * * * *

19 THEREUPON, the Meeting was concluded.

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4 STATE OF KENTUCKY)
5 COUNTY OF FAYETTE)
6

7 I, JOLINDA S. TODD, Registered
8 Professional Reporter and Notary Public in and for
9 the State of Kentucky at Large, certify that this
10 transcript is a true and accurate record of the
11 Dental Technical Advisory Committee meeting.
12

13 My commission expires: August 24, 2027.
14

15 IN TESTIMONY WHEREOF, I have hereunto set
16 my hand and seal of office on this the 8th day of
17 July 2024.
18

19
20 JOLINDA S. TODD, RPR, CCR(KY)
21 NOTARY PUBLIC, STATE AT LARGE
22
23
24
25

DR. BOBROWSKI: [64] 3/4 3/7 3/17 3/19 3/25 4/7 4/9 6/18 7/23 8/2 8/4 11/14 12/1 12/11 14/2 15/20 16/7 16/17 16/19 17/6 18/2 18/22 20/10 20/21 21/20 22/1 23/16 24/18 25/16 25/20 25/22 28/20 29/17 30/13 31/1 31/3 31/19 34/17 34/25 35/3 35/8 39/3 42/8 42/24 44/2 46/9 54/5 55/4 55/6 56/2 56/7 56/10 56/13 56/21 57/23 60/16 65/21 66/23 67/3 67/18 67/23 67/25 68/12 68/17	1st [1] 53/24 2 20 [2] 37/21 41/2 20140 [2] 5/20 6/15 2024 [3] 1/16 3/1 69/17 2027 [1] 69/13 2028 [2] 52/5 52/6 2031 [1] 52/9 21 [1] 40/21 22 million [2] 27/13 30/6 24 [1] 69/13 24th [1] 65/24 26 [1] 31/18 28th [2] 12/15 22/5 29.95 [1] 35/12 2:00 [3] 1/17 3/2 66/14	absolutely [1] 16/16 accept [3] 23/23 31/12 53/5 acceptable [1] 62/11 accepting [5] 31/8 52/16 57/21 58/5 64/2 access [4] 27/14 41/5 41/9 41/11 accommodate [1] 17/4 according [5] 5/19 9/13 10/18 43/2 46/6 accounts [1] 32/6 accurate [1] 69/10 accused [1] 22/9 across [4] 25/7 26/8 28/13 60/20 act [1] 31/6 active [4] 18/14 53/16 57/8 57/17 actual [1] 35/10 actually [2] 42/15 62/8 acute [1] 12/21 ADA's [1] 52/1 add [4] 24/10 25/5 26/12 55/22 added [7] 9/23 12/13 22/16 22/18 23/3 23/8 24/20 addition [1] 21/22 additional [2] 16/13 22/6 address [3] 7/24 37/2 38/18 addressed [2] 11/24 63/9 adequate [1] 8/17 adjourn [1] 68/10 adjudicate [1] 12/10 adult [4] 8/8 15/15 57/17 63/17 adults [5] 5/12 25/4 25/5 25/18 25/20 advance [1] 11/12 Advisory [1] 69/11 aesthetics [2] 35/4 35/6 Aetna [1] 31/6 affect [1] 29/23 affected [2] 27/15 30/18 affecting [2] 24/17 27/19 afford [2] 36/17 36/18 afraid [1] 31/25 after [4] 13/5 14/18 18/10 55/24 afternoon [2] 30/15 44/19 again [16] 5/15 10/10 10/23 13/23 13/24 22/21 23/6 23/10 23/12 27/5 33/20 41/23 45/20 50/15 55/11 66/10 AGD [1] 49/3 age [9] 17/3 40/20 40/21 40/22 42/18 56/19 57/12 58/2 60/7 aged [2] 57/3 57/10 agenda [6] 3/10 5/4 6/10 17/8 39/21 39/25 ages [3] 40/18 42/22 43/4 aging [2] 59/9 60/7 ago [11] 18/5 19/9 19/25 25/13 32/17 46/23 50/20 50/23 50/25 53/21 65/4 agree [2] 33/5 34/22 ahead [2] 12/6 32/8 ahold [2] 61/3 62/9 aimed [1] 9/9 air [5] 46/14 51/1 51/6 51/9 51/12 all [45] 4/7 4/8 4/18 4/18 4/23 5/1 12/11 12/18 14/10 16/1 16/21 17/13 17/23 20/21 21/15 21/21 24/20 25/11 26/2 29/17 30/16 30/18 32/10 38/4 39/19 40/2 41/21 44/18 45/8 48/17 53/11 55/25 56/4 56/10 56/12 56/17 59/4 65/7 65/10 65/21 68/9 68/12 68/13 68/13 68/14 all's [1] 13/4 Allen [1] 4/13 allow [1] 45/19 allowances [1] 11/25
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