CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
EMERGENCY MEDICAL SERVICES
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
July 17, 2023
Commencing at 2:04 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

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1 **APPEARANCES**

2

3 **BOARD MEMBERS**:

4 Keith Smith - Chair

5 Linda Basham

6 Dana Evans

7 Troy Walker

8 Joe Prewitt

9 Jacob Carroll

10 Joshua Brand (not present)

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1 **P R O C E E D I N G S**

2 CHAIRMAN SMITH: Would you mind

3 calling roll call for us, please?

4 MS. BICKERS: Okay. So I have

5 Keith.

6 CHAIRMAN SMITH: Present.

7 MS. BICKERS: Our new member,

8 Joshua, is he here?

9 CHAIRMAN SMITH: Joshua Brand, are

10 you on by chance?

11 (No response.)

12 MS. BICKERS: I've got Linda. I

13 see her logged in right here, but I don't

14 hear her. Linda, you're on mute.

15 MS. SHEETS: We seem to always have

16 problems hearing Linda.

17 CHAIRMAN SMITH: Yeah. She just --

18 her IT folks just got her speaker and camera

19 changed out, so she should be able to sign in

20 here in a moment.

21 MS. BICKERS: Okay. I see her

22 logged in. Maybe we just can't hear her, so

23 I'll move on.

24 Dana?

25 MS. EVANS: I'm here.

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1 MS. BICKERS: Joe?
2 (No response.)
3 MS. BICKERS: Troy?
4 MR. WALKER: I'm here.
5 MS. BICKERS: Okay. And Jacob?
6 MR. CARROLL: I'm present.
7 MS. BICKERS: Okay. It looks like
8 you have everyone except Joshua and Joe.
9 CHAIRMAN SMITH: Okay. Joshua had
10 an email issue that -- their company just
11 changed their email addresses around, so the
12 email we were originally given is an inactive
13 email. So I sent him another link earlier
14 today and was hoping he might be able to jump
15 on. But we will see if he gets on here in a
16 moment. Like I said, Joe said he would get
17 on as well as soon as he left the one meeting
18 he was in so...
19 So let's go ahead and jump into the meat
20 and potatoes of why we've asked for this
21 meeting today. We've discussed at several of
22 the prior meetings about the prior
23 authorization issue that we've got that is
24 severely causing issues with providers being
25 able to get reimbursed for the Medicaid

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1 transports that they're performing.
2 Let me also point out again this is a
3 special meeting, so we have to stick to the
4 agenda as it's written, and we can't discuss
5 anything other than what is on the agenda.
6 So what we would like to accomplish in
7 today's meeting is, first off, find out the
8 data elements that the MCOs must have and the
9 information that EMS needs to have in order
10 to come up with hopefully a form that we can
11 use as a medical necessity statement and not
12 necessarily be used as a prior authorization
13 form in itself.
14 Because, apparently, the big issue that
15 the prior authorizations are causing is the
16 fact that the prior authorization has to be
17 submitted before the claim is submitted. And
18 because, typically, EMS cannot get that
19 information before arriving to a hospital,
20 it's pretty routine that the claim
21 information is sent in pretty much as soon as
22 the crew syncs with the -- at the end of the
23 transport and the information goes, which
24 then creates an issue.
25 So as we discussed in our last meeting,

1 we were wanting to look at potentially doing
2 away with the prior authorization and
3 replacing that with a medical necessity
4 statement that could go in with the claim
5 when the claim is done similar to how the
6 Medicare PCS form is currently handled.
7 So from the perspective of defining
8 data -- required data elements, from our MCO
9 perspective, what information do you or must
10 you have from our EMS crews on a medical
11 necessity statement in order for you to be
12 able to either evaluate or process a claim
13 for EMS to be able to be reimbursed? And
14 I'll open the floor up to the MCOs to be able
15 to comment.
16 MR. OWEN: This is Stuart Owen with
17 WellCare.
18 CHAIRMAN SMITH: Hey, Stuart.
19 MR. OWEN: Yeah. Good afternoon,
20 Keith. Yeah. In looking -- you know,
21 looking at the form -- I've got a copy of it
22 up. I could share it. I think this is what
23 you all sent as an example. I can share
24 that.
25 I think from prior -- thank you, Erin.

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1 Let me -- prior discussion, there's a
2 question about diagnosis. But, you know, the
3 form doesn't have diagnosis but that that
4 could be included on the claim, if I
5 understand correctly. Like, the diagnosis
6 could be -- I mean, that would be submitted
7 on the claim along with this form.
8 And this form is, you know, basically
9 the physician saying it was medically
10 necessary for the person to be transported
11 via ambulance, not through other ways,
12 because. And then I just see, you know, a
13 lot of kind of just basic information, I
14 guess, patient information and stuff.
15 So -- and I'm looking at the Medicare
16 one. Let me -- I believe this is it. Are
17 y'all seeing a form?
18 CHAIRMAN SMITH: Yes. That's very
19 similar -- that's a little bit different from
20 the --
21 MR. OWEN: Oh, okay.
22 CHAIRMAN SMITH: -- MCS -- or
23 the -- I'm sorry, the PCS form that Medicare
24 has. However, by the looks of this form, it
25 is very similar, but it is a little

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1 different.

2 MR. OWEN: Oh, okay. Yeah. Well,

3 I mean, do you have -- because I thought I

4 was pulling that one up, but I probably --

5 apparently, I pulled up a different one.

6 CHAIRMAN SMITH: No. That -- I was

7 just curious. This one may have been sent

8 out, and I did not see it. But this is the

9 first time I've seen it.

10 MR. OWEN: Okay.

11 CHAIRMAN SMITH: Are there any

12 other members from the TAC that have seen

13 this form?

14 MR. OWEN: Let me scroll up and see

15 what this -- the source of it -- I think this

16 came -- I believe there was maybe a law firm

17 that sent somebody on the TAC this template.

18 CHAIRMAN SMITH: Yeah. No. We've

19 gotten -- we've used the PCS form from a law

20 firm that looks a little bit different than

21 this.

22 MR. OWEN: Oh, okay. All right.

23 Well, when I look at this one -- and I

24 presume the other one is the same way -- it

25 seems like -- because there's just a lot of,

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1 you know, basic member information that you
2 would have to have and date and transfer and
3 all that and then the physician statement.
4 And I could see, you know, as long as that's
5 on there -- you know, I guess the question is
6 if anything is missing, is it, therefore,
7 incomplete, you know.
8 CHAIRMAN SMITH: Sure.
9 MR. OWEN: I mean, so, like, this
10 patient -- last name, first name, date of
11 birth, gender, certifying
12 physician/practitioner. Name.
13 (Brief audio interruption.)
14 MR. OWEN: I've got an echo.
15 MS. BICKERS: I muted everyone.
16 Sorry about that, Stuart.
17 MR. OWEN: That's all right. You
18 know, with their NPI, place of employment,
19 name, address, date of order. And I guess
20 that's the order for the transport, transport
21 from and to.
22 Number of transports requested in a
23 60-day period, I don't understand that, why
24 that would --
25 CHAIRMAN SMITH: I believe -- I'll

1 answer that but then let's get to Judy's
2 question because she's got her hand up.
3 MR. OWEN: Okay.
4 CHAIRMAN SMITH: Typically, when
5 you see a comment like the number of
6 transport requests in a 60-day period, it's
7 going to be a recurring. So let's say it's
8 going to be a kidney dialysis --
9 MR. OWEN: Oh.
10 CHAIRMAN SMITH: -- or something
11 along that line.
12 MR. OWEN: Okay. So it's a series.
13 Okay.
14 CHAIRMAN SMITH: Yeah. Typically,
15 with Medicare, you only have to fill that out
16 if it's going to be recurring in a 30-day
17 period, so that's typically what that's
18 about. But let's see real quick what Judy
19 had there. So, Judy, go ahead.
20 DR. THERIOT: Hi, Keith. I was
21 just wondering, as a provider, the -- what if
22 you can't check any of those boxes? So let's
23 say the patient goes to the emergency
24 department via ambulance, and none of those
25 things apply. So then the physician cannot

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1 certify that they needed to come by
2 ambulance. So what happens then?
3 MR. OWEN: This is nonemergency.
4 Like, they're already at the hospital or
5 facility; right? And then now they need a
6 nonemergency -- it's not the emergency;
7 right?
8 CHAIRMAN SMITH: Right. This would
9 be for nonemergency.
10 DR. THERIOT: So leaving the --
11 okay. I am so sorry.
12 MR. OWEN: No. You're all right.
13 CHAIRMAN SMITH: And, Suzanne, you
14 had a question.
15 MS. LEWIS: Yes. Hi. Suzanne
16 Lewis from UnitedHealthcare. And I think one
17 of my questions was just answered. When I
18 was looking at the form, it said nonemergent
19 transport services, so that's correct? This
20 is for nonemergent transport?
21 MR. OWEN: Yes.
22 MS. LEWIS: Okay. And, you know,
23 we use -- United has a company that we use
24 for nonemergent stretcher transport services,
25 and we have a form that we already use. And

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1 I don't have it right in front of me right
2 this second, but are you trying to -- and I
3 apologize. I'm coming into this, I think, a
4 little bit late. But are you trying to get
5 all the MCOs to use a single source -- or a
6 single form for the nonemergency transport
7 services?
8 CHAIRMAN SMITH: Yeah. What we
9 would like to do is a couple of things.
10 No. 1, have a single form but to be able to
11 get information that is attainable by the EMS
12 crew when they go to pick up a patient.
13 Because on the form right now for the
14 preauthorization, it's asking for information
15 that is virtually impossible for an EMS
16 provider to be able to get and submit prior
17 to a claim being submitted.
18 And part two of that would be to change
19 the process a bit to where, instead of it
20 being a prior authorization form, that it
21 would be a medical necessity statement that
22 would go along with a claim so that it all
23 goes in together so that we're not looking at
24 two different submissions, two different
25 actionable items.

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1 Because the more forms that we're
2 sending in at different times, the more
3 chances we have of a claim not being able to
4 get reimbursed because of something either
5 going before the other form goes in or
6 missing documentation or something along
7 those lines.
8 MS. LEWIS: Okay.
9 CHAIRMAN SMITH: So what the heart
10 of the matter is we want to eliminate
11 barriers so that those claims that truly need
12 to be reimbursed and truly are medically
13 necessary can be done and the provider get
14 reimbursed for it.
15 MS. LEWIS: Okay. Thank you for
16 clarifying that for me. I think the -- yeah.
17 So I would -- I would agree with what Stuart
18 was saying. I know that, like, if there's a
19 diagnosis code, if -- and a statement from
20 the physician regarding the medical
21 necessity, that the patient is unable --
22 (audio glitch). I think those are all very
23 important.
24 But if there is, like, an ICD-9 code --
25 I'm sorry. ICD-10 or a diagnosis code

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1 that -- any codes that can be put on this as
2 well, if they have it. Is that something
3 that the doctor's office -- I mean, it seems
4 like the doctor's office would have to fill
5 that out; right?
6 CHAIRMAN SMITH: It is something
7 that if the transport is originating from the
8 hospital where we're picking up the patient
9 at, we should be able to get an ICD-10 code
10 or --
11 MS. LEWIS: Yep.
12 CHAIRMAN SMITH: -- we can keep it
13 as generic as possible so that -- let's say a
14 person is going home due to a -- and I'm just
15 going off the top of my head here -- due to a
16 complication to diabetes. We could put an
17 ICD-10 code that may not be the exact ICD-10
18 code but gets it into the ballpark so that
19 you know that it is kidney disease for why
20 we're doing the transport.
21 That may have been a bad example to use.
22 But, essentially, we would use or try to keep
23 the ICD-10 codes in a general area if we
24 can't get a specific -- hopefully, we would
25 be able to get a specific. But as we have

1 found out in some of the hospitals we go
2 into, when they go into either Epic or
3 Cerner, whatever program they're looking for,
4 even sometimes the providers have a hard time
5 finding what is the most accurate ICD-10 code
6 because there are so many different ICD-10
7 codes now.
8 MS. LEWIS: Yes. Okay.
9 MR. OWEN: Is the -- would you
10 have -- I mean, is it likely that you can get
11 it then? Or if not -- because I know
12 somebody is going to put it on the claim.
13 Would it be the same thing -- same diagnosis,
14 you know? I mean, is it pretty, like, common
15 that you're going to get it at that time?
16 CHAIRMAN SMITH: I would think it
17 would be fairly close. I don't think that
18 you would find a reason for transport to be
19 radically different than what you would find
20 on the claim as a reason for transport.
21 MR. OWEN: So I guess that's
22 something. I mean, because this is -- if I
23 recall correctly, 21 days would be the
24 deadline from transport to submit the form
25 and the claim. So, obviously, there would be

1 time to synchronize and make sure that the
2 diagnosis --
3 CHAIRMAN SMITH: Well, the 21
4 days -- let me have either Linda or Dana
5 explain that because they know that part of
6 it much better than I do. But I believe the
7 21 days is -- that is the time frame to where
8 if additional information is requested or
9 something along those lines. But let me open
10 it to either Linda or Dana to be able to
11 explain the 21 days a little bit better.
12 MS. BASHAM: Okay. I think you can
13 hear me now?
14 CHAIRMAN SMITH: Yeah. You're
15 good.
16 MS. BASHAM: Okay. This is Linda.
17 And the 21 days I didn't get to thoroughly
18 explain last time. When we carry a Medicare
19 transport patient, a nonemergency, we are --
20 if the doctor does not sign off on the
21 medical necessity at the time of transport,
22 before or after, we are allowed 21 days to
23 send for his signature to verify that this
24 patient met medical necessity at the time of
25 transport.

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1 However, at the end of 21 days -- and we
2 have it documented that we've sent for it.
3 In other words, we've got either certified
4 mail that we sent for it or a signed
5 authorization book from the post office that
6 shows we sent for it. If we don't -- are not
7 able to obtain it in 21 days, then we are
8 able to bill Medicare for payment without
9 that PCS form. But we have to keep that
10 documentation that we attempted to receive it
11 on file.
12 That's another point I wanted to make,
13 is with Medicare -- if we are truly to follow
14 Medicare, Medicare does not require us to
15 submit the Physician Certification Statement.
16 They require us to have it or have the signed
17 certification. We've tried to get it.
18 So what they can do, though, is they can
19 come back and say we want to see the
20 documentation on this run. Then we are
21 required to submit the trip report and the
22 PCS form.
23 So there's not a matter of having to
24 send the Physician Certification Statement
25 every time to Medicare. So if we're going to

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1 follow those guidelines, that's also
2 something to consider.
3 CHAIRMAN SMITH: That's a good
4 point. Thank you, Linda. So from that
5 perspective, what's the thoughts of our MCOs
6 that are on the line?
7 DR. GALLOWAY: Yeah. This is
8 Dr. Galloway from Humana.
9 CHAIRMAN SMITH: Yes, ma'am.
10 DR. GALLOWAY: We met internally
11 and discussed, and I think we are fine with
12 submitting the form and the information with
13 the claim. But, you know, since this is on
14 our prior authorization list, you know, we
15 would require, you know, documentation to
16 support what's on the form with submission of
17 the claim. Because, you know, we will review
18 it as a post-service review on the back end.
19 CHAIRMAN SMITH: Okay. So, in
20 other words, then, for any of the -- and if
21 I'm mistaking -- for all the Humana claims,
22 we would have to have the Physician
23 Certification Statement to accompany the
24 actual claim that the billing companies, or
25 the EMS service if they don't use a billing

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1 company, would have to send in electronically
2 or physically in order to get reimbursement.
3 Am I stating that correctly?
4 DR. GALLOWAY: Yeah. We would
5 require, like I said, your trip report and
6 your clinical information to back up what's
7 on the form, I mean, so that we could
8 actually do a review.
9 CHAIRMAN SMITH: Okay.
10 MS. BASHAM: Did you say a copy of
11 the trip report as well?
12 DR. GALLOWAY: Well, that would be
13 part of the clinical information, yes.
14 MS. BASHAM: Okay. Please be
15 advised that sometimes the hospital will
16 document something on a PCS form that the
17 crews do not personally observe at the time
18 of the trip. So there -- and that is what we
19 have to bill off of, so they may not always
20 coincide completely.
21 DR. GALLOWAY: Well, it would be
22 all part of the information, I mean, what
23 occurs at the hospital that's documented on
24 the form and -- as well as what your EMTs,
25 paramedics document in their trip report.

1 That all would be considered clinical
2 information.
3 MS. BASHAM: Okay. Thank you.
4 CHAIRMAN SMITH: Okay. So Humana
5 would still -- would like to have the form
6 and the claim form at the same time. Are
7 there any of the other MCOs online that would
8 like to follow that same stance, or are there
9 others that are okay with getting the form by
10 exception as opposed to getting them all the
11 time as the way Medicare currently does?
12 MR. OWEN: Yeah. And, Keith, I'll
13 have to discuss internally. Because we've
14 had meetings, and we all talked about, you
15 know, providing the form, that that would be
16 the new process.
17 CHAIRMAN SMITH: Sure.
18 MR. OWEN: So I'll have to talk
19 with them about that.
20 CHAIRMAN SMITH: Okay. Okay.
21 MS. MCNAMARA: Hi, Keith. This is
22 Wendy McNamara from Aetna Better Health of
23 Kentucky. And we're very similar to Humana's
24 process, it sounds like. We're quite
25 aligned, it sounds like. We would require a

1 prior authorization form as well as the
2 medical records and the medical necessity
3 form from the providers.
4 I want to kind of encourage the MCOs
5 from getting away from using the word "prior"
6 when we're saying prior authorizations. We
7 just need -- Aetna Better Health of Kentucky
8 requires an authorization to accompany your
9 claim.
10 So we all know that the State of
11 Kentucky has a 12-month submission to submit
12 your claim, so I feel like we are able to
13 extend the time frame in which the EMS
14 providers can submit their documentation.
15 So we're willing to meet you halfway a
16 little bit, but we still require that same
17 information, so the medical necessity of the
18 medical records and your claims. But the
19 sequence in how the EMS providers are
20 submitting is vital, I feel like.
21 And I also want to ask you a couple of
22 questions. I've been involved in the last
23 few meetings. I'm sensing that maybe we need
24 some provider education back to our EMS -- or
25 I'm sorry, back to our hospital providers to

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1 better assist you. I feel like there's some
2 barriers there. I don't know if you would
3 agree with that.
4 Are you seeing on your end where the
5 hospitals are just very reluctant to submit
6 the proper paperwork timely? I have a
7 20-plus year background in emergency room
8 nursing medicine, and, you know, never once
9 did I have an EMS crew show up that I didn't
10 have that form prepared for them and a copy
11 of records.
12 So it sounds like you guys are chasing
13 it around, and I want to just, you know,
14 touch on that. Do we need to provide
15 education to our hospital providers?
16 CHAIRMAN SMITH: I think, to that
17 point -- and I'll open it up to the other EMS
18 providers to comment how they would like. I
19 think the problem isn't so much that they
20 don't know it. The problem is they don't
21 have the staffing to do it. That's the
22 problem --
23 MS. MCNAMARA: Sure.
24 CHAIRMAN SMITH: -- we're running
25 into everywhere, both for EMS services to

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1 comply with this and the hospitals. I mean,
2 sometimes we're doing good to catch up with
3 the doctor or nurse to get a signature to
4 begin with, let alone to get this other
5 information --
6 MR. WALKER: Hey, Keith.
7 CHAIRMAN SMITH: -- that we're
8 going to have to provide. Yes.
9 MR. WALKER: Sorry, guys. I'm live
10 from D.C., and it's loud here. So to answer
11 her question, the hospitals -- there's no
12 requirement that says the hospitals have to
13 give us preauthorization information like it
14 does Medicare, so I know several hospitals in
15 my area just stopped doing it. Just the last
16 two months, my hospital said they don't have
17 time to do the pre-auths. They'll help us
18 the Medicare PCS's because they are actually
19 required. The pre-auths aren't, and they're
20 refusing to do that so just --
21 MS. MCNAMARA: Yeah. And valid
22 point there, Troy. But I think that's where
23 we as the MCOs need to kind of come together
24 and just remove that -- the term "prior" from
25 the term "authorization." Because we're just

1 expecting you to get an authorization. It
2 doesn't really have to happen -- we certainly
3 don't want you to avoid taking the trip. You
4 know, if the patient needs transported, they
5 need transported. We don't want to delay
6 that. So I feel as the MCOs, we need to get
7 away from calling it a prior auth and call it
8 just an authorization.
9 And, you know, take your trip. Get the
10 patient transported. Provide the care. But
11 then we need to maybe relax the time frame
12 from where we will allow you to request an
13 authorization at that point with the
14 appropriate documentation, give you as the
15 provider -- EMS providers, that is, the
16 adequate time to get whatever necessary
17 documents you need and so that we can, you
18 know, submit your claim and -- or process
19 your claim timely at that point.
20 MR. WALKER: Yeah. We agree,
21 especially --
22 MS. MCNAMARA: Would that help you?
23 MR. WALKER: Yeah, especially with
24 the ERs.
25 MS. MCNAMARA: Yeah.

1 MR. WALKER: If you take a patient
2 that's inpatient at the hospital and you've
3 got case managers, it's not really an issue
4 there as much as it is ER --
5 MS. MCNAMARA: Right.
6 MR. WALKER: -- where you have only
7 nurses that are just not going to waste their
8 time with it.
9 MS. MCNAMARA: I understand.
10 MR. WALKER: Yeah. That's where
11 it's hardest. And, you know, as far as
12 getting medical equipment -- I'm going to
13 have to jump off here. But, you know, a lot
14 of our ambulance services aren't allowed to
15 get background or health care, all the
16 different stuff, history of medical and
17 things like that from the hospitals because
18 they're not part of that hospital.
19 MS. MCNAMARA: Yeah.
20 MR. WALKER: So we can't get all
21 that documentation to back it up. But as far
22 as, you know, the run form and stuff like
23 that, that's no trouble at all. But when it
24 comes to health records and ICD-10 on what
25 they're in the hospital for, that's our

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1 biggest -- biggest problems.
2 MS. MCNAMARA: So would it help to
3 extend the time frame in which you can submit
4 that documentation?
5 MR. WALKER: I don't --
6 MS. MCNAMARA: And do you have the
7 resources to chase that clinical and to chase
8 that information?
9 MR. WALKER: No. Not a lot of
10 resources, and it doesn't -- to me, amount of
11 time doesn't matter because the hospitals
12 aren't going to give you medical history of a
13 patient if you're not part of that
14 institution so...
15 MR. OWEN: What if we made this
16 form essentially a post auth, you know, a
17 window afterward, like what Wendy is talking
18 about, however many days after the fact, not
19 PA, but the auth request has to include this
20 form?
21 CHAIRMAN SMITH: The form that
22 we're currently showing on live or the --
23 MR. OWEN: Yeah. Well, the PCS
24 form, the Physician Certification.
25 CHAIRMAN SMITH: The current --

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1 yeah. To your point, Stuart, that current
2 form that we have -- the current prior
3 authorization form, it's basically nearly
4 impossible to get. So if we can adopt this
5 form and maybe change some rules around, that
6 would -- that could be palatable.
7 Joe, you had your hand up. What would
8 you like to comment?
9 MR. PREWITT: Well, this is Joe
10 Prewitt. I got on a little bit late. But
11 our problem is, you know, after -- if we
12 don't get or capture the information at the
13 time of the transport -- I know in my local
14 hospital, I'm not going to get it after that.
15 The other problem is -- and I like the
16 idea. I think there needs to be a lot of
17 education done with the hospitals. But then
18 those folks that have been educated move on
19 somewhere else. The nurses move on. New
20 nurses come on board. That information
21 doesn't get passed down.
22 So your scheduling -- in my case, the
23 scheduling clerk that schedules these
24 transports usually gets into an argument with
25 the nurse that's calling it in because it's

1 not their problem to get this information.
2 It's our problem to get this information.
3 And it's back and forth, back and forth.
4 So if the PCS form can be adopted, all
5 our staff pretty much across the state know
6 to get that form on the nonemergency
7 transports. And anything -- whether you call
8 it prior authorization or you call it
9 authorization, whatever that has to transpire
10 after that, it doesn't matter what the time
11 frame is. It's not going to happen.
12 Like Troy said, if we're not a part of
13 that hospital group, then they're not too
14 concerned about whether or not we get their
15 information.
16 MR. OWEN: Yeah. I guess there's
17 no consequences to the hospital.
18 MR. PREWITT: Exactly.
19 CHAIRMAN SMITH: They just want the
20 patient moved.
21 MR. OWEN: Yeah. Well, so maybe
22 this form -- you know, this form is the post
23 auth, you know, is what would have to be
24 submitted, is a post auth request. I guess
25 that's what we're talking about.

1 CHAIRMAN SMITH: Yeah. So if we
2 say that the PCS form will work -- this could
3 be a hypothetical here. Hypothetically,
4 we're saying that the PCS form is what we
5 will start using and turning in with the
6 claim. That will have to be turned in by our
7 billing companies or through our EMS services
8 that choose to do their own billing for all
9 Medicaid claims for patients in Kentucky.
10 Am I sounding right so far?
11 MR. OWEN: Yeah. Well, and I'm
12 thinking it would be like the auth process.
13 It really wouldn't even be -- it wouldn't
14 have to be with the claim. You know what I
15 mean?
16 CHAIRMAN SMITH: Yeah.
17 MR. OWEN: And I don't know -- but,
18 basically, your auth request would be -- and
19 we'd have whatever deadline -- would be
20 submitting this form, is kind of what I'm
21 thinking.
22 CHAIRMAN SMITH: Sure. So long as
23 we can establish that a service won't be
24 penalized if the auth form comes in after the
25 claim comes in.

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1 MR. OWEN: Right.
2 CHAIRMAN SMITH: Because sometimes
3 one form -- actually, a lot of times, one
4 form can come in before the other, whether
5 it's electronic or hard copy. That's all
6 semantic at this point.
7 But the fact is sometimes some
8 information will come in before others, and
9 that's been one of the things that have
10 triggered a lot of the denials so far, have
11 been because the prior auth didn't come in
12 before the initial claim was received. And,
13 therefore, the EMS service wasn't allowed to
14 claim a reimbursement for that run.
15 So that's -- I think that's one
16 technicality we definitely need to clear up
17 if we can all agree on it.
18 MR. OWEN: Yeah. Because that
19 would be -- there would have an auth -- like,
20 it's a different team. The claims processing
21 team would look to see was there an auth.
22 And if it hadn't been submitted yet, then
23 they would say no auth, I'm sure. It would
24 be automatically denied, no auth. So we
25 would have to sync --

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1 CHAIRMAN SMITH: Okay.
2 DR. GALLOWAY: Well, I --
3 MS. LEWIS: I'm sorry. This is
4 Suzanne from United. I just wanted to jump
5 in here real quick. I would have to take
6 this away to my team because -- Stuart, what
7 you were saying. You know, there is an auth
8 process that we have to follow, and there is
9 information that needs to be gathered,
10 obviously.
11 And I don't -- having just a single form
12 may or may not have all of it. We may need
13 medical records just like I think the
14 person -- and I apologize. I don't remember
15 her name. The person from Aetna was saying,
16 you know, there is a process. There is
17 information. There is documentation that's
18 required to ensure that medical necessity is
19 being met on the -- you know, on the front
20 end.
21 And I get that -- like, we don't want to
22 delay care. We do not want to delay any of
23 that, and this is kind of the gathering of
24 information. But there's still that piece
25 that has to be done before that claim can be

1 paid.
2 And so I think what you're asking -- it
3 sounds like what you're asking is to waive
4 the auth process and submitting everything at
5 one time on the back end for a claim. Is
6 that what I'm hearing? Because that's what
7 it sounds like to me.
8 I just feel like there's something
9 that's -- like, you're trying to kind of put
10 it all at the end, like at the back end.
11 CHAIRMAN SMITH: Suzanne, you
12 actually broke up there when you were
13 speaking, and part of your one sentence
14 didn't come through. I hate to ask you to
15 repeat that, but could you re-summarize that
16 again?
17 MS. LEWIS: Yeah. Sorry. It
18 sounds like what you're asking is, like, for
19 us to waive that auth process and, instead,
20 submit a form with a claim and not require an
21 auth. That's kind of what I think I'm
22 hearing, and I just wanted to ask for
23 clarification.
24 CHAIRMAN SMITH: Yeah. In a
25 perfect world, we'd love to have it mirror

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1 the same Medicare program that we already
2 comply with and meet the same rules as
3 Medicare. Whereas -- that's what Linda had
4 just brought up a little bit ago, that,
5 essentially, it's only -- approvals are only
6 done as an exception, if you will, so that
7 only if they see something, with the
8 electronic submission, do they say they want
9 to see the actual PCS form or actual claim
10 form. Otherwise, they let it go through as
11 filed.
12 And that -- ultimately, that would be
13 what we would like to see, simply to be able
14 to keep the amount of work and paperwork down
15 on our EMS crews because of the fact that
16 getting this information from the hospitals,
17 in some cases, is like pulling teeth.
18 And as Troy has pointed out and Joe
19 mentioned, for a lot of these EMS services,
20 if they're not part of the hospital system,
21 they're not going to get access to the
22 records that they need in order to get paid.
23 And at the end of the day, that's -- as much
24 of a dirty topic as money is, if we don't
25 have the reimbursements, we're going to cease

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1 to exist.

2 MR. WALKER: Hey, can I talk one

3 more time just -- Keith, and I'll get off

4 here.

5 CHAIRMAN SMITH: Absolutely.

6 MR. WALKER: Yeah. I think, you

7 know, the reason for the meeting is to find

8 out -- I think the only way we're going to

9 get this ball rolling is to find out exactly

10 what information the MCOs are needing to have

11 on the form and then let's look at that

12 information and see what's capable.

13 The biggest question -- you know,

14 they've got to require certain stuff, and I

15 completely agree with that. But medical

16 records and ICD-10 from the hospital is not

17 something we could readily get for every

18 service.

19 There are a few of us that are

20 hospital-based ambulance services, and we can

21 get that information. But for the most part,

22 they can't get that information. So you have

23 to go by what's on the run form that the EMT

24 and paramedics fill out. That's what we do

25 have access to.

1 So I would like to just see us -- you
2 know, what the meeting was for is to find out
3 what information is needed for this form from
4 each of the MCOs, so we can start a process
5 and try to come up with a form.
6 MR. OWEN: I'm thinking that maybe
7 a proposal is there's still auth but that it
8 would be submitting this form, and it would
9 be after the fact. That's kind of what
10 I'm -- like, within a given deadline.
11 MR. WALKER: Yes.
12 CHAIRMAN SMITH: Right.
13 MR. WALKER: Yes. That's what we
14 do with Medicare. Once we make the form, we
15 fill out -- actually, the doctors and nurses
16 help us. They'll fill out the PCS form. We
17 then submit that along with a run form if
18 that's what we need to, to Medicaid, to the
19 MCOs.
20 That's kind of in a gist the way
21 Medicare does it. And they don't require
22 medical records or anything from the
23 hospital. So that's the whole reason behind
24 all this.
25 MR. OWEN: So I guess that's kind

1 of the proposal for us, the MCOs, to kind of
2 huddle, I guess, and see if we can do that.
3 MR. WALKER: Yeah.
4 CHAIRMAN SMITH: Right.
5 MR. WALKER: Yeah. And to come up
6 with the information. Because, by all means,
7 the form that we submitted as an example is
8 definitely -- we can add little things and
9 maybe even take away some things from that
10 form. But we just need to know what is
11 required of your MCO to get started on it.
12 MS. MCNAMARA: Troy, this is Wendy
13 McNamara from Aetna Better Health again. So
14 the form that's being shown right now is
15 sufficient. I personally, like others,
16 probably would need to have the NPI of the
17 provider that's sending the patient,
18 obviously the member demographics, et cetera.
19 And then the EMS provider's ICD-10 code
20 if -- would be required as well as your codes
21 for transport, ground or air. And I think
22 where -- I like the mobility piece of this.
23 MR. OWEN: Let me scroll down, too.
24 There may be more.
25 MS. MCNAMARA: Yeah. That would be

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1 helpful.

2 MR. OWEN: Whoops.

3 MS. MCNAMARA: Yeah. All of this

4 looks good. I think everything that's on

5 this form is what we would require for claim

6 submission for Aetna Better Health.

7 MR. OWEN: Could this be considered

8 the auth request? Like, literally, you've

9 got to submit an auth request, and it is this

10 form. And the request is actually this form,

11 is what's provided.

12 MS. MCNAMARA: Yeah. We would have

13 enough information on this particular form to

14 build a case, to build an authorization

15 request. So that would eliminate the

16 standardized PA request form that the state

17 of Kentucky has; correct, Keith?

18 CHAIRMAN SMITH: Yes.

19 MS. MCNAMARA: Okay. For Aetna

20 Better Health, this is sufficient.

21 DR. BRUNNER: This is Dan Brunner

22 from Anthem. Is there -- at the top, is

23 there a place for the -- at least the

24 Medicaid ID number of the patient?

25 CHAIRMAN SMITH: Yeah. It says

1 Medicare ID, but we can change that --
2 DR. BRUNNER: A Medicaid ID. Okay.
3 Because I like how Wendy said it. We've got
4 to take the prior out of the authorization.
5 We don't require a prior auth for emergent or
6 nonemergent transports as long as it's a
7 participating provider in our network.
8 But, you know, our ops team is on the
9 call here as well, and they can comment. But
10 on the back end, we would at least need --
11 like you said at the beginning, when you're
12 submitting the claim form, there's an ICD-10
13 code on there; correct, Keith?
14 MR. OWEN: That's a field. That's
15 a field, I think, on every claim.
16 DR. BRUNNER: And, Keith, you
17 would --
18 CHAIRMAN SMITH: Linda. Linda or
19 Dana, can you confirm that? Because y'all
20 are the ones who see these claims when they
21 go in. I don't.
22 MS. BASHAM: I'm sorry. What was
23 the question?
24 DR. BRUNNER: When you file the
25 claim, is there -- Keith mentioned at the

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1 beginning that there is a diagnosis on the
2 claim form or an ICD-10 code?
3 MS. BASHAM: Yes. We put an ICD-10
4 code on the 1500.
5 DR. BRUNNER: Okay. I think -- I
6 mean --
7 MS. BASHAM: We don't -- we are not
8 allowed to put anything other than the
9 patient's -- this first block. We're not
10 allowed to complete anything else on this
11 Physician Certification Statement.
12 DR. BRUNNER: Okay. Because --
13 MR. OWEN: So that --
14 DR. BRUNNER: -- I think that would
15 be sufficient to build the claim because
16 we -- like you said, we've got to take the --
17 at least, Anthem, we take the prior out of
18 the authorization process.
19 MR. OWEN: And, Wendy, I think you
20 were saying you would like that ICD-10 code
21 on this form.
22 MS. MCNAMARA: Yes.
23 MR. OWEN: If so -- yeah. You
24 know, I guess that would be -- you know, we
25 could customize it. It's going to be

1 Kentucky Medicaid. Would that -- would that
2 be an issue for you all? It would be an auth
3 form, and it would have that diagnosis. And,
4 again, it's retro. It's after the fact.
5 MS. MCNAMARA: And, Keith, I'll
6 just back that up real quick before you
7 answer. You know, the ICD form that you
8 would put on -- or ICD code that you would
9 use on this form, it does not -- for Aetna
10 Better Health, it does not have to match
11 what's on the final claim if -- as long as
12 we're in the ballpark. You know, like, the
13 example that you used, I think you're solid
14 from us.
15 CHAIRMAN SMITH: Yeah. That was
16 part of our concern as well because --
17 especially when they changed the ICD-9 to 10
18 and things were so -- made so micro, that
19 everybody was concerned that if they put
20 something other than what somebody else put,
21 are they going to get -- is somebody going to
22 come in and say that's fraud, and now you're
23 going to be subjected to audits because
24 somebody thinks what you're doing is
25 fraudulent because you misquoted an

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1 alphanumeric code that was in part of the
2 ICD-10 code, if you were even given that. So
3 let me jump over -- Dana, you've got your
4 hand raised. Go ahead.
5 MS. EVANS: Yes. I just wanted to
6 clarify because you guys are speaking of this
7 form and stating that -- some of you are
8 stating that this form will be okay to
9 utilize and that you think it has everything
10 on there that you need.
11 But my question is to the MCOs. Are you
12 still going to require us to submit this
13 first and then you come back with an
14 authorization number before we can submit our
15 claim? Or are you going to allow us to
16 submit this form along with the claim and
17 then it be utilized as an authorization?
18 And, at that point, deny for -- that it
19 doesn't meet medical necessity based off the
20 information on here with the claim, or are
21 you looking for it to be submitted prior to
22 us submitting the claim?
23 MR. OWEN: Yeah. And I think
24 that's what we need to huddle, you know,
25 respectively with each MCO, our MCOs

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1 internally. I guess for you all, you know, I
2 mean, would you prefer it just be part of the
3 auth? Like, this is an auth request, and it
4 does not have to be filed with the claim.
5 DR. GALLOWAY: This is Dr. Galloway
6 from Humana. We already discussed this
7 internally, and we can make it a cleaner
8 process if it is -- the form is submitted
9 along with the run sheets with the claim and
10 then we can just get the claim, do a
11 post-service review, and, you know, then
12 process it at that point, either -- as the
13 information meets medical necessity or not.
14 I mean, it's cleaner for us to do it that
15 way.
16 MR. RANDALL: This is Jeremy
17 Randall from Anthem, and I would agree with
18 that statement as well. Like, the form can
19 be submitted with the claim, and we can do
20 the clinical review at that point.
21 CHAIRMAN SMITH: Okay.
22 MR. OWEN: Would it be submitted to
23 the UM auth team or filed with the claim as
24 an attachment? I guess that's what I'm
25 wondering.

1 MS. BASHAM: It would be filed with
2 the claim attached.
3 MR. RANDALL: Anthem agrees with
4 that. Yep.
5 DR. GALLOWAY: That's how it would
6 be with Humana, also.
7 MR. OWEN: Okay. Claim submittal
8 process.
9 DR. GALLOWAY: Yeah.
10 MR. OWEN: Okay.
11 DR. GALLOWAY: It would be sent to
12 us on the back end over to UM to look at it
13 before the claim was processed so...
14 MS. EVANS: So just to clarify, the
15 Physician Certification Statement would be
16 submitted with the claim. It's not
17 necessarily being considered an authorization
18 or a prior authorization. It will be
19 reviewed at the time the claim is processed
20 and determined at that point whether the
21 information meets medical necessity or not.
22 CHAIRMAN SMITH: I believe that's
23 the way this is going, Dana.
24 MS. LEWIS: Yeah. Hey, Keith, it's
25 Suzanne. I just want to make sure. So it

1 sounds like we're saying that the auth
2 process is no more and that what we want on
3 the back end is to submit the form with the
4 claim, and it's all done at one time. That's
5 what I thought; right?
6 CHAIRMAN SMITH: That's correct, if
7 I'm hearing this correctly.
8 MR. OWEN: Yeah. I was going to
9 say that's what I -- that's what I just
10 heard, because it is different. That's what
11 I was trying to figure out. Is it still
12 going to be auth, or is it going to be claim?
13 Because it's two different processes, you
14 know.
15 MS. LEWIS: Yeah. So I think that
16 does require me to take it back to my claims
17 team and look at this and look at how we can
18 do this on the back end. And my apologies.
19 I don't have a copy of this form. So if -- I
20 put a note in the chat with my email address.
21 If somebody could drop that in an email to
22 me, I would greatly appreciate it. And I can
23 take this back to our claims team and our
24 medical director and take a look at this and
25 see what we can do and then get back to you

1 all with an answer. How soon do you --
2 CHAIRMAN SMITH: Yeah. I think
3 we -- I think this particular form, if this
4 is going to be the form that we're going to
5 use, then it needs to go out to everybody.
6 Personally, I have not seen this
7 particular draft of it, so I think it needs
8 to go out to all the TAC members. It needs
9 to go out to all the MCOs. It needs to go to
10 everybody so that we're all on the same page.
11 We all know what the form is. And the
12 additional data points that you asked for, we
13 can note what those need to be to be added
14 onto the form.
15 MR. OWEN: Yeah. I was going to
16 say, if you all have one -- have the one that
17 you're -- that you have or whatever, you
18 know, and could send that out, I mean, that's
19 fine as well. This was the one that I had --
20 I forget where. I thought it came from
21 somebody on the TAC, but I could be wrong.
22 CHAIRMAN SMITH: Yeah. It refers
23 to --
24 MR. OWEN: I mean, I can send this
25 out. I can send this out. But I was going

1 to say if you all have a version that you're
2 comfortable with and would rather send out,
3 you know, that's obviously fine.
4 CHAIRMAN SMITH: Yeah. Linda, go
5 ahead.
6 MS. BASHAM: I'm sorry. I think
7 the --
8 MS. BICKERS: I looked through my
9 records. And, Stuart, I believe I sent it to
10 you, and Linda sent it to me. So I'll look
11 through that and try to get that out.
12 CHAIRMAN SMITH: Yeah. Go ahead,
13 Linda.
14 MR. OWEN: And I've heard so far --
15 it's just ICD-10 and the Medicaid ID are the
16 only changes I think I've heard.
17 MS. BASHAM: Steve.
18 CHAIRMAN SMITH: Yeah.
19 MS. BASHAM: This -- this
20 particular form here that I'm seeing, it
21 looks to be a two-page report certification,
22 and it is going to require recoding for a lot
23 of the hospitals that already have the
24 standard PCS form in it. But we know it's
25 going to have to have some revisions to be

1 able to accommodate everyone's need.
2 MR. OWEN: If y'all have an easier
3 form, that's fine.
4 CHAIRMAN SMITH: Well, there's
5 another form that is out there. It's a PCS
6 form that came from a law firm that it's all
7 on one page.
8 MR. OWEN: Oh, okay.
9 CHAIRMAN SMITH: So we can make it
10 a one-page but yet give you the information
11 you need. To me, shorter is better so long
12 as we're providing the information. But when
13 we start adding two pages, I'm just, in my
14 mind, envisioning crews making photocopies of
15 pages and then forgetting to put page 2 on
16 there and then we're having to go back and --
17 it's going to become a cluster if we're not
18 careful so...
19 MR. OWEN: Yeah. I totally agree.
20 If you all could send the form you have to
21 everybody, that would be great. One page
22 sounds wonderful.
23 CHAIRMAN SMITH: Yeah. We'll be
24 happy to send that out and -- so that we're
25 not missing anything, we know that we need to

1 change the terminology from Medicare to
2 Medicaid on it, and we need to add the ICD-10
3 code.
4 Was there any other information that, as
5 of now -- granted, you all have to take it
6 back to your teams to discuss. But as we sit
7 here right now, is there any other data
8 points that you can think of that is required
9 that we need to have on this form?
10 Because what we can do is we can -- we
11 can do some template work here to incorporate
12 all this so that we can send you what the
13 current PCS looks like right now that we have
14 and then have somebody that's really good at
15 doing forms -- I'm not that person -- to come
16 up with a generic to send out to make sure
17 everybody is good with it. But if there's
18 more information we need to put, let's get
19 that identified.
20 Yes, Linda. Go ahead.
21 MS. BASHAM: So I want to clarify
22 that they do want the facility who is signing
23 this, completing this form, to put an ICD-10
24 on here. They are not going to accept the
25 words of a diagnosis or a complaint; is that

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1 correct?

2 And the second point I want to confirm,

3 I want to make sure that -- look in Section 3

4 down here where it's got start date, end

5 date. That Section 3 is intended to be for

6 dialysis patients, wound care patients,

7 patients who have long-term, routine

8 transportation. If you will notice, that has

9 up to 60 days that that portion is normally

10 good for. We haven't spoken about that.

11 But when you're taking a patient to

12 dialysis three times a week and picking them

13 up three times a week, it's a great burden to

14 have to get a PCS form every time. Medicare

15 does not require that. They require us to

16 get one form with a start and end date and to

17 get it updated every 60 days. So that's two

18 points.

19 MR. OWEN: That's a great point.

20 Maybe we could have a section that says

21 dialysis. Well, I guess it's

22 radiation/chemotherapy as well.

23 MS. BASHAM: Yes.

24 MR. OWEN: Anything that's a series

25 of transportation -- does the Medicare one

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1 have this section? Do you know or --
2 MS. BASHAM: Yes. Yes.
3 CHAIRMAN SMITH: Yeah. And the
4 Medicare one, the one thing that Linda was
5 talking about where it's got words instead of
6 ICD-10 code, it spells out contractures, or
7 it spells out unable to ambulate. So instead
8 of it having an ICD-10 on there, it's
9 specifically stating what the reason is, why
10 the patient has to go by an ambulance instead
11 of using the ICD-10 code.
12 So does it -- is it mandatory that it
13 has to be in code form, or will plain
14 language be suitable for the reason for
15 transport?
16 MR. OWEN: And, Wendy, I think you
17 were the one talking about the ICD-10 code.
18 Is that kind of -- what are your thoughts on
19 that?
20 MS. MCNAMARA: As far --
21 MS. BASHAM: Now, don't you -- I'm
22 sorry.
23 MS. MCNAMARA: Go ahead, Linda. Go
24 ahead, Linda.
25 MS. BASHAM: I was going to say,

1 you will have the ICD-10 codes on your 1500.
2 MR. OWEN: On the claim.
3 MS. BASHAM: On the claim.
4 MS. MCNAMARA: Yeah. I mean, I
5 think if we -- if we can get the ICD-10 code
6 on here ballpark, like I mentioned, I think
7 we would be fine. They're going -- we should
8 only be accepting what's on the final claim
9 submission, though. That should -- in our
10 opinion, when we're processing claims, that's
11 what we require.
12 As far as the dialysis, the number of
13 trips, Stuart, is that what you were asking
14 me? I'm sorry.
15 MR. OWEN: Yeah. Yeah. That's the
16 scenario we have to deal with.
17 MS. MCNAMARA: You know, my -- this
18 is my thoughts on that. I think that if we
19 are going down the route of needing to set up
20 long-term -- what I would consider long-term
21 ambulance transportation for that scenario
22 alone, then we would want to get that
23 established prior to the services being
24 initiated with approval for X number of
25 units. You know, so you would want to -- you

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1 would kind of want to look at those from,
2 like, a true prior auth type of standpoint.
3 Would you agree with that? Because the
4 services haven't happened yet, and you're
5 arranging it for multiple trips. And if you
6 have one authorization on file for, say --
7 let's say ten trips, then it would be up to
8 the EMS provider to initiate a new
9 authorization when they have exceeded or met
10 that limit.
11 DR. GALLOWAY: Yeah. This is
12 Dr. Galloway with Humana. I would concur
13 because we do not have a way in our claims
14 system to set it up so that the multiple
15 claims would pay. I mean, if they -- if we
16 set up the process, the form has got to be
17 there with the run sheet and that stuff, then
18 that's what it's going to have to be for
19 everyone. I mean, that -- we can't set up
20 multiple processes on the claim side.
21 So I agree with Wendy. This would be a
22 true prior authorization just like any other,
23 and you would need to just do it on the front
24 end and get it approved. So that way, when
25 those claims come in, it would look for the

1 prior authorization and would pay --
2 MR. OWEN: Would we separate --
3 DR. GALLOWAY: -- without having to
4 submit the information multiple times.
5 MR. OWEN: Would we separate that
6 and make that not part of this but a separate
7 thing, you know, PA for series but take it
8 out of this process, so to speak?
9 DR. GALLOWAY: I would think so,
10 and I will have to check with our claims, how
11 we can set that up for it to know to look. I
12 mean, that, again, may get a little tricky.
13 But, you know, I would -- I can't speak for
14 our claims, but I would think we could come
15 up with something to set that process up.
16 CHAIRMAN SMITH: Yes, Linda.
17 MS. BASHAM: And Medicare and our
18 providers are used to -- they call it
19 repetitive trips on these patients. They are
20 used to having to have that done ahead of
21 time.
22 So first -- they might be able to make
23 the first week of trips while they're getting
24 that. But after the first, say, ten trips,
25 then they have to have the repetitive or the

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1 prior authorization set up. And Medicare
2 gives them an authorization number the same
3 as you would in this type of case.
4 CHAIRMAN SMITH: Okay.
5 MR. OWEN: That would be separate,
6 I think, it sounds like, that scenario from
7 this.
8 MS. MCNAMARA: Yes. I would agree.
9 CHAIRMAN SMITH: Yeah. We'd have
10 to come up with a separate form, then, for
11 the repetitive.
12 MR. OWEN: Right.
13 CHAIRMAN SMITH: Would it --
14 because sometimes it's going to take time
15 between the time that the dialysis is ordered
16 from the time it gets approved. Are you all
17 good with, let's say, setting an arbitrary
18 number, like nine or ten transports that can
19 occur with reimbursement while the process is
20 being done to review -- subject to review so
21 that we don't potentially put a patient or
22 delay a patient from getting dialysis while
23 we wait on a prior authorization for us to be
24 able to do that, such as how Medicare does
25 it?

1 MR. OWEN: Yeah. I know I would
2 have to huddle that internally.
3 CHAIRMAN SMITH: Did I say that
4 good, or did I confuse that even worse?
5 MR. OWEN: No. I completely
6 understand. I'd have to huddle internally
7 with -- I completely understand what you're
8 saying, though. It's basically kind of auth
9 after a threshold. After so many visits,
10 then the auth kicks in for more.
11 CHAIRMAN SMITH: Yeah. But,
12 essentially, because it is dialysis, we don't
13 want to sit back and tell a patient you're
14 going to have to wait a week or two to get
15 authorization if a doctor has ordered it to
16 begin immediately. We don't want to wait for
17 a prior auth because we want to go ahead and
18 take care of the patient right then and there
19 and then know that it's being worked in the
20 background but know that those claims are not
21 going to necessarily be thrown out simply
22 because it was done before we had an
23 authorization received.
24 MS. MCNAMARA: So in my opinion, on
25 that scenario, Keith, what I would do is just

1 submit an individual trip until you have a
2 prior authorization established for a set
3 number of units. I would follow that same
4 process.
5 CHAIRMAN SMITH: Okay. Dana and
6 Linda, are y'all good with that?
7 MS. BASHAM: Yes.
8 MS. EVANS: As long as that's
9 working for you guys, yes.
10 MR. OWEN: Does Medicare define
11 repetitive, or is it -- I guess it's just
12 anything that's multiple trips.
13 MS. BASHAM: Yes. They do define
14 it.
15 CHAIRMAN SMITH: Okay.
16 MS. LEWIS: This is Suzanne. I'm
17 going to ask another question again. I just
18 want to make sure I'm understanding. It
19 sounds like there's two things here. We're
20 going to do -- we want to waive claims --
21 sorry. We want to waive PA for that
22 single-use, nonemergent transport and allow
23 the PCS form to be submitted with a claim,
24 not requiring prior auth. That's the first
25 thing.

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1 The second thing is for repetitive
2 trips -- the example given was dialysis --
3 that we would have a similar --
4 (Brief audio interruption.)
5 MS. LEWIS: Can you hear me?
6 CHAIRMAN SMITH: Yes, ma'am. Go
7 ahead.
8 MS. LEWIS: That you have a similar
9 form that would be filled out, but it would
10 require additional review. And it would go
11 through a regular PA process, prior auth
12 process. Is that what I'm hearing?
13 CHAIRMAN SMITH: Yes. I believe
14 that's correct.
15 MS. LEWIS: Okay. That's the
16 proposal. All right. I just want to make
17 sure I'm clear on that. I have to take this
18 back to my team for clarification. And like
19 I said, my CMO is going to have to review it
20 and make sure she's okay.
21 CHAIRMAN SMITH: Sure.
22 MS. LEWIS: But yeah. Okay. Good.
23 Thank you.
24 CHAIRMAN SMITH: Dr. James, did you
25 have a question?

1 DR. JAMES: Let me come off mute.
2 No. I was getting another phone call. But
3 the only comment I was going to make is
4 asking a medical director about claims issues
5 is fraught with danger. I'm taking notes on
6 everything that you said and want to get back
7 to the right people.
8 CHAIRMAN SMITH: Yeah. One of the
9 things that will occur with this is we'll get
10 a -- at the end of it, in a few days, we will
11 get a transcript of the entire meeting done
12 by a court reporter, and they are exceedingly
13 accurate so...
14 DR. JAMES: I hope this form will
15 also get approval from DMS. It really helps
16 if we have DMS not only for its own
17 traditional Medicaid people but also saying
18 that it's got the blessing. Things move
19 faster that way.
20 CHAIRMAN SMITH: Linda?
21 MS. BASHAM: Currently, Passport is
22 not requiring prior authorizations. Are you
23 going to follow the same trend as everyone
24 else here, or are you going to maintain your
25 current process, Dr. James?

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1 DR. JAMES: I don't see a reason
2 why we would change things. But if there's a
3 form that should be married up with claims to
4 make it easier and consistent for everybody,
5 whatever works.
6 CHAIRMAN SMITH: Okay. So the form
7 that we finalize, come up with, get
8 everybody's buy-in on, we would need to go
9 ahead and submit to Erin or Kelli. Kelli or
10 Erin, would you all be able to take it and
11 start it through the process within Medicaid
12 services, or is there another process we need
13 to follow for that?
14 MS. BICKERS: I'm going to ask
15 Angie Parker if she can answer that because I
16 know there is a process that the MCOs submit
17 documents to DMS for approval, and that's
18 just a tad bit out of my wheelhouse. So,
19 Angie, do you mind to answer that?
20 MS. PARKER: Each MCO is to submit
21 any forms that are utilized for providers to
22 DMS for approval. I've been sitting here
23 listening to a lot of the conversation, and I
24 feel that I haven't -- I don't think I was on
25 the last meeting or, if I was, not the whole

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1 meeting regarding this challenge that DMS --
2 EMS is having with each of the MCOs on their
3 different forms or different requirements.
4 It is certainly our expectation that --
5 and it sounds like it's going to happen, that
6 the MCOs are working together to have a
7 similar position on how this is obtained.
8 But whatever the final form is going to be,
9 it would be -- the MCOs would have to submit
10 that for DMS approval unless DMS were to
11 develop a form and say, MCOs, this is the
12 form you need to use for EMS authorizations.
13 DR. JAMES: And you know, Angie,
14 when you tell us to jump, we say how high.
15 MS. PARKER: I mean, we can always
16 step in on this process to help it, but it
17 sounds like it's -- right now, it's been a
18 collaborative discussion on how best to
19 rectify the challenges that EMS is having.
20 CHAIRMAN SMITH: Yeah. I think,
21 quite honestly, the way this has gone so far
22 with everybody being willing to work with one
23 another and to come up with a solution, I'd
24 much rather to continue going down this road,
25 a collaborative effort, as opposed to turning

1 it over to the state and saying, hey, we've
2 got a problem. Fix it. Everybody gets a
3 black eye when we do that. So if we can work
4 on this together and come to a solution, then
5 I think that that's going to be more
6 palatable.
7 MS. PARKER: Now, I can't answer,
8 per se, to the fee-for-service side of things
9 for the ambulance, and I don't know if you've
10 been having challenges with the
11 fee-for-service authorizations or not or even
12 if it requires it. So that side, I'm not
13 familiar with.
14 CHAIRMAN SMITH: You know, fee for
15 service, we could probably hold you up for
16 another conversation. That would be much
17 longer than what we've got time for today to
18 discuss.
19 MS. PARKER: Okay.
20 CHAIRMAN SMITH: Without a doubt.
21 Okay. So --
22 MR. OWEN: Chief, do you have
23 the --
24 CHAIRMAN SMITH: Yes.
25 MR. OWEN: Do you have the --

1 sorry, the form or somebody that has the form
2 that -- the one-pager that can send to
3 everybody? I just want to make sure that
4 goes out.
5 CHAIRMAN SMITH: Yeah. I think,
6 Kelli, did you -- or I'm sorry. Erin, did
7 you just send out an email that it has been
8 sent to the group?
9 MS. BICKERS: Yes. I attached an
10 email where I had originally sent it out in,
11 I believe, April. So I re-sent all that out
12 to everyone and grabbed the emails that were
13 dropped in the chat.
14 MR. OWEN: Wonderful. Thank you.
15 Thank you. Thank you, Erin.
16 CHAIRMAN SMITH: Okay. So it
17 sounds like we've got a good basis for what
18 information needs to be on the form, what
19 forms need to be used for what.
20 I sure wouldn't want to be the court
21 reporter having to be the one to take all the
22 notes for today's meeting. That's for sure.
23 One of the questions that also has come
24 up, moving down to Item No. 3 on the agenda
25 here, was the qualifications for persons

1 reviewing the medical appropriateness.
2 The question was brought up -- because
3 with Medicare, there's a rule that the people
4 that are reviewing the claims need to have a
5 medical background equal to -- somebody
6 correct me if I'm wrong. But, essentially,
7 they've got to be -- have medical backgrounds
8 so that it just doesn't become a string of
9 denials just simply because, and it's
10 somebody that is medically educated that
11 knows what is being indicated on the form.
12 So that was a question that came up, is:
13 Who actually reviews the forms, and do they
14 have a medical background?
15 DR. GALLOWAY: Well, for Humana, it
16 would go through our normal nurse review.
17 And if she didn't feel like she could
18 approve, it would go to our medical director
19 to look at.
20 CHAIRMAN SMITH: Okay.
21 MS. PARKER: Only a doctor can deny
22 medical necessity.
23 CHAIRMAN SMITH: Okay.
24 MS. MCNAMARA: That's correct.
25 That's the same process for Aetna Better

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1 Health. Nurse reviewer and sent to the
2 medical director for medical necessity
3 reviews prior to claim submission.
4 MR. OWEN: Yeah. And that's in our
5 statute and our contract with DMS.
6 CHAIRMAN SMITH: Okay. Again, that
7 was a question that came up, so I wanted to
8 make sure that we had the opportunity to
9 discuss real quick.
10 I don't think Item No. 4, vote to accept
11 the basis of the form. I think based off
12 the -- and if y'all think differently, please
13 tell me. But I don't think we need to vote
14 at this point because we don't have a form to
15 actually vote on.
16 But I think based off the conversation
17 we've had and based on the comments from all
18 of our MCOs that are on the call, which is
19 Aetna, WellCare, Humana, UnitedHealth,
20 Anthem, Passport, that we are -- in principle
21 agree to what needs to be on the form, what
22 the forms will need to be used for. And we
23 will now be able to take this back and
24 develop another form that we can send to the
25 group.

1 And what I would like to do is send this
2 new form out prior to the next meeting so
3 that hopefully, at the next meeting, we can
4 discuss and vote on the form to make sure
5 everybody is good with it and hopefully adopt
6 it as soon as possible so that we can start
7 to get the reimbursement claim process going
8 in the right direction for EMS again.
9 Does anybody have any comments about
10 that process or taking that approach? Yes,
11 Linda.
12 MS. BASHAM: Can I also get a copy
13 of the PCS form that was up here initially?
14 MR. OWEN: Yeah. The --
15 MS. BASHAM: The two-page one so
16 that I can look at anything there that is not
17 on the one-page that we might need to add in.
18 MR. OWEN: Yeah. The one that I
19 shared, Linda?
20 MS. BASHAM: Yes.
21 MR. OWEN: Yeah. Sure. I'll send
22 that to Erin to send out to everybody.
23 MS. BASHAM: Thank you.
24 MR. OWEN: Sure.
25 MS. LEWIS: Yeah. And I just want

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1 to -- Keith, is it okay to clarify? You said
2 that we're taking this back. Each MCO is
3 taking it back. I know some folks have said
4 it's not a problem, but I still need to
5 clarify that with my team so...
6 CHAIRMAN SMITH: Absolutely. Yeah.
7 MS. LEWIS: Okay.
8 CHAIRMAN SMITH: Yeah. And let's
9 do this. If there is something that gets
10 brought up -- if -- let's say your claims
11 team comes back and says, you know, there
12 needs to be a little bit of a cleanup --
13 MS. LEWIS: Yeah.
14 CHAIRMAN SMITH: I know we're not
15 supposed to do official meeting stuff without
16 being in a meeting. But if it is a
17 technicality as far as, you know, something
18 misspelled, something out of place, I think
19 that's something we can make a change on
20 without having to meet and make the agreement
21 to do it. But if it is something that we
22 have to pull everybody back together, then
23 we'll have to wait to August to do it.
24 But if it is a simple change, email it
25 to the EMS TAC for us to be able to take a

1 look at it, and perhaps we can just
2 incorporate it into the form. Send it out to
3 everybody and let it be reviewed again so
4 that we're not making this process
5 potentially go longer than what we have to if
6 everybody is okay with that.
7 MS. LEWIS: That works for me. I
8 think that works for me, is to do it through
9 email if we have questions. Yeah.
10 MR. OWEN: Yeah. I agree.
11 MS. MCNAMARA: Same.
12 MS. BICKERS: If you can just make
13 sure to filter all of that through me, I
14 would appreciate that. This is Erin.
15 MS. MCNAMARA: And, Keith, this is
16 Aetna Better Health. You know, I would make
17 a suggestion. I don't know what the other
18 MCOs -- how they feel about this, but I feel
19 like once the form is decided upon and agreed
20 upon, that you as the EMS take it to DMS for
21 the DMS to enforce. It would make life a
22 little bit easier for everybody and improve
23 consistency.
24 CHAIRMAN SMITH: Sure. Absolutely.
25 I'm also -- I also sit on the Kentucky Board

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1 of EMS. So once we get this form to
2 everybody's liking and gets approval, I'll
3 take this to our next scheduled board
4 meeting, make sure everybody is aware of it.
5 And we can get it blasted out and get the
6 widest dissemination we can.
7 In fact, from a timing perspective, if
8 we approve this -- or if the TAC approves
9 this in August, our next meeting is at the
10 EMS convention conference that is down in
11 Lexington, which we get some of our best
12 attendance for board meetings at that
13 conference. So it would probably be the best
14 place to disseminate the word about this. So
15 from a timing perspective, it seems to be
16 lining up fairly well.
17 MS. BICKERS: Keith, I will send an
18 email to the MCOs to request -- your next
19 meeting is on the 28th, so I'll request that
20 they have that to me -- I believe the 21st is
21 the Monday prior.
22 Wendy, if you don't mind to drop your
23 email -- Wendy with Aetna. I don't believe I
24 have your email contact, so I can just email
25 the people in this group just to request that

1 by the 21st to get it out for review prior to
2 the next August meeting.
3 MS. MCNAMARA: Sure thing.
4 MS. BICKERS: Thank you.
5 CHAIRMAN SMITH: Outstanding. That
6 was a fantastic segue into Item No. 6, which
7 is the meeting date which is August 28th from
8 2:00 to 4:00.
9 And I've got two sixes there. I
10 apologize for that. Auto numbering did not
11 catch that for me. I apologize.
12 With this being a special meeting, I
13 would typically ask if there was any comments
14 or anything from everyone. But because it is
15 a special meeting, we're not supposed to do
16 that.
17 So I will ask, though, is: Are there
18 any last comments about the form or the
19 process that we've discussed today that
20 you're just now thinking of or something we
21 need to consider, or is everybody good?
22 Going once.
23 MR. OWEN: I can't think of
24 anything.
25 CHAIRMAN SMITH: Awesome. Very

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1 good. I like it when something comes
2 together. Sounds great.
3 Folks, I cannot thank you enough for
4 being willing to work with us on this.
5 Anything we can do to help our EMS providers
6 get the reimbursement they need to survive is
7 a good thing, and the opportunity to be able
8 to work together as a group and accomplish
9 that, I think, speaks volume to the group and
10 being able to work together. So, again,
11 thank you all very much.
12 With that, we'll have a vote for
13 adjournment.
14 MR. PREWITT: Motion.
15 CHAIRMAN SMITH: Motion by
16 Mr. Prewitt to adjourn. Is there a second?
17 MS. BASHAM: I'll second.
18 MS. EVANS: Second.
19 CHAIRMAN SMITH: Okay. Linda and
20 Dana both seconded. All those in favor,
21 signify by saying aye.
22 (Aye.)
23 CHAIRMAN SMITH: Opposed?
24 (No response.)
25 CHAIRMAN SMITH: Awesome. Very

1 good. Thank you all very much and look
2 forward to speaking with you again very soon.
3 MR. OWEN: Thank you. We all
4 appreciate you having this emergency meeting.
5 We appreciate it. It was very helpful.
6 CHAIRMAN SMITH: Thank you all.
7 (Meeting concluded at 3:14 p.m.)
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2 C E R T I F I C A T E

3

4 I, SHANA SPENCER, Certified

5 Realtime Reporter and Registered Professional

6 Reporter, do hereby certify that the foregoing

7 typewritten pages are a true and accurate transcript

8 of the proceedings to the best of my ability.

9

10 I further certify that I am not employed

11 by, related to, nor of counsel for any of the parties

12 herein, nor otherwise interested in the outcome of

13 this action.

14

15 Dated this 31st day of July, 2023.

16

17

18 *_/s/ Shana W. Spencer_*

19 Shana Spencer, RPR, CRR

20

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