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

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Via Videoconference
January 10, 2023
Commencing at 8:30 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dale Lynn, Chair

Linda Derossett

Kresta Wilson

Emily Sacca

Renea Sageser

MR. LYNN: Good morning, everyone, and thanks for attending this meeting. The agenda is up on the Zoom link. And the first part of old business is a discussion on the possibility of increasing provider reimbursement in the First Steps program for OT, PT, and speech. That was still on the agenda last week -- I mean, last -- two months ago, and I think we decided that we wanted to take that to the MAC.

But then the meeting ended before we ever got anything written up about that, and I think Kresta was going to write something up -- is that right, Kresta -- and submit it so I can take that to the MAC.

MS. WILSON: I didn't recall that being the case. And I was looking through the minutes last night, and I was like, hmm. Like, I feel like maybe I was supposed to do something with that, so I certainly can.

MS. BICKERS: Dale, my minutes show that you lost your quorum before you could vote on the recommendations, so I would do that in this meeting.

MS. WILSON: There we go.

MR. LYNN: Yeah. That's what happened, I think.

MS. BICKERS: Kelli's internet crashed, so if you give me just a minute, I'll get your agenda pulled back up.

MR. LYNN: Sure.

MS. WILSON: But I can definitely do something, Dale. I guess I'm curious exactly the format of what you're --

MS. SAGESER: Kresta, we -- I had one I submitted to -- for the Kentucky Speech and Hearing Association, like a white-page letter. I can email you that and then you can take from that what we want to use if we agree on some of the terms in there. It talks about just some reimbursement stuff. Because I had already written a white letter for the legislators.

MS. WILSON: Okay. That sounds great. Yeah. And we were also going to bring up --

MR. LYNN: If we can get that written up today and vote on it before the end of this meeting, that would be perfect.

MS. WILSON: And I think we needed

to bring up something about -- did we want to talk about training or something?

MR. LYNN: Yeah. The extensive amount of training there is involved. There are a lot of --

MS. WILSON: Yeah. That's been, like, an ongoing thing, so I'm not sure.

MR. LYNN: -- folks in therapy that keep dropping out because it's too costly to do that.

MS. WILSON: Right. Right.

MS. SAGESER: So we're talking about two issues here, just to clarify. One is First Steps reimbursement increase that we're wanting to take before the MAC; correct?

MR. LYNN: That is correct.

MS. SAGESER: Okay.

MR. LYNN: And the other one should probably go to the MAC as well, for their assistance about the extensive -- maybe cutting back the extensive training.

MS. SAGESER: Uh-huh. And the training.

And then the other thing in this letter

that we had sent was just reimbursement in general for straight Medicaid as well. Is that going to the MAC? I wasn't on last month, so maybe that's new business today that we want to also take.

MR. LYNN: Yeah. I think in new business, there was concern by a provider that has some difficulty hiring OT, PT, and speech because of the very low reimbursement rate. That's in new business.

So the next thing on the --

MS. BICKERS: Hey, Dale. You haven't -- sorry. This is Erin. You haven't established your quorum yet to vote on your minutes or anything, so if you want to do that first. I'm sorry. I didn't mean to cut you off.

MR. LYNN: That's all right. You're fine.

MS. BICKERS: That way, we can get down into the agenda and make sure your quorum is established.

MR. LYNN: Yep. We do have a quorum. It's myself, Dale Lynn; Renea; Kresta; and Linda.

And I guess we do need to vote on -- or review and approve the November minutes. Did everybody get a chance to look at those?

MS. SAGESER: I wasn't at the last minutes (sic), so I don't know if Kresta or someone else wants to approve those just because I don't know.

MR. LYNN: Yeah. I read them extensively, and they look accurate to me.

MS. WILSON: Yeah. I looked through it all last night. Everything looks good. So I'll make a motion to approve.

MS. SAGESER: And I'll second that.

MR. LYNN: All right. All in favor?

(Aye.)

MR. LYNN: All right. We already addressed the first item that we're going to vote on before the end of this meeting.

And the second item is a follow-up regarding a UHC policy that peer-to-peer be with the referring physician rather than the providing therapist.

Is there any update on revisiting that policy?

MR. KERN: Good morning, Dale. This is Chris Kern with UnitedHealthcare. Can you all hear me?

MR. LYNN: Yeah. Good morning, Chris.

MR. KERN: Good morning. I do have an update that I can share. I have Dr. Cantor with me today, and so she may wish to also add.

So we did go back and take this under consideration after the last Therapy TAC call, and we have implemented a therapy provider peer-to-peer process. It is actually underway now.

But formally, we're going to have everything completely put into place for this as of 2/1. But we are implementing it internally now so that if there's a peer-to-peer that requires -- be required with UnitedHealthcare, that the therapist will be able to work with a therapist on that peer-to-peer. So that's done and ready to go.

Just want to make sure that -- just letting you know that all initial approvals

can be made with a nurse or PA. However, if there is a denial or an overturn of a denial or an uphold of a denial, that discussion would still need to come from a medical director following any peer-to-peer call between the therapists at United and the therapy provider. So let me pause there and see if there are any questions.

MR. LYNN: That sounds reasonable to me.

MS. MARSHALL: Dale, I'd like to add to that. So thank you to Dr. Cantor. I think she's listening. We met on this as my role -- I'm Pam Marshall -- my role in the reimbursement -- as the reimbursement chair for the Kentucky OT Association.

And she had open ears, willing to listen to us. And as we asked questions, there's a question we really should bring up to the TAC as well. And they had required, you know, this peer-to-peer, but it also stemmed from language in the regulation in one of the KARs that talks about "in collaboration with" are the words, in collaboration with a physician.

And, you know, those words were

interpreted as the physician needs to sign the plan of care, and the physician, then, would need to be the one to do the peer-to-peer and all of that.

So they were able to go back to that regulation and realize that, you know, it's -- it's not necessary for us to go to that extreme, just with the difficulty with, you know, holding up -- it holds up therapy. If you've got to wait on an order -- not an order but a plan of care being signed, you've got to put that child on hold until you get it back, and it becomes an administrative issue.

So I just want to say kudos to them for looking at it and being able to make things work for kids getting therapy so...

DR. CANTOR: Good morning, Pam. Nice to see you. Thank you for that.

Just to add on to what Chris was talking about, right now, this month of January, with a couple of weeks left, if a peer-to-peer comes in, we'll be working on it to create the therapist-to-therapist call. But starting in February, when it was actually

able to have it fully implemented, if it's an OT, ST, then that's the type of therapist that will be speaking to the requesting therapist.

And right now, we do have a physical therapist on staff who's been assisting us, but that's -- so I'm very excited about having that like specialist be able to carry on that conversation.

And the laws that are in the KAR are about a medical director adjudicating it, but I think that our whole flow, the process that we're creating around this, should make it just better for all of you all, for all the providers. And I'm hoping that -- that's our intention, so putting a plan in place.

Thanks.

MS. WILSON: Yes. I'll second that, Pam. Thank you very much, Dr. Cantor. I think that makes a big difference in us being able to talk to like professionals and being on the same page and understanding the problems that, you know, the children are having. So that makes -- that makes a world of difference, so thank you.

DR. CANTOR: I did find out that InterQual does have pediatric therapies as part of their policies. Because we do use InterQual although we have UHC pediatric therapy policies. But InterQual, based on the hierarchy, is first. So that -- that is out there, but I think like specialists makes a huge difference, so great.

MR. LYNN: Thank you, Dr. Cantor. We appreciate that.

The third old business on the agenda is claim code issues. NCCI edits are released quarterly. Any update on the timeline from DMS or MCOs on a timeline of uploading NCCI edits?

MR. KERN: This is Chris Kern with United. So we did go back with this from the last call, and we do have a process in place. In fact, (audio glitch) -- a department that is primarily charged with reviewing new NCCI edits that are released. And there is a process in place for us to evaluate any changes and then implement that into our system on a quarterly basis.

If you need something that's more

specific to an exact timeline, I can get that for you and provide that in a follow-up to this call. But we do have a process to implement once they do come through.

MS. MARSHALL: Hey, Dale, can I ask a more specific question? So -- really to all the MCOs and to DMS. So this is something I've been working on for a couple of years through AOTA and with the National Reimbursement Team, is there's -- CMS produces an NCCI edit that is Medicare. And most insurance companies will use that, but they also use the Medicaid NCCI edit.

And I feel like that's not paid attention to as much on the national level to, you know, terminate codes that are on that list. So the two lists are a little different, and there's code sets and code Column 1/Column 2 code pairs that aren't paying now that a lot of our MCOs are using a third party like Cotiviti. There's sets that have been removed from Medicare and sets that are still on Medicaid.

So what I've learned is that most MCOs, because they're using third party -- and even

if they're not, they're sometimes loading all of those edits. So I think it would be helpful for our team to understand what edits are being loaded in systems. Are both that Medicaid and Medicare?

And then to ask the question: Can we work on the state level -- if there's code pairs that should not be on the Medicaid one, can we work on that through TAC and submitting it to the MAC to remove those codes that really should be?

Because the premise is, just so everybody on this call understands, you know, in the land of therapy, especially pediatric therapy, which is, you know, the majority of Medicaid that we're talking about, it's one therapist to one child. They can only bill one code in one 15-minute period.

So there's no -- you know, those edits were put in place to keep people from upcharging or doing duplicate services or that whole bundling idea. And what happens to our claims is we're just billing what we do, but it comes back with the Column 2 codes unpaid. And the claim denials don't say you

need medical records, but that's what's needed to then -- you know, you have to submit medical records and do an appeal and do second-level appeals.

And it's very time-consuming, especially when you have hundreds and hundreds and hundreds of claims affected, maybe thousands of claims affected. It's kind of an impossible situation. And when the claim edit shouldn't even be there in the first place because it's not -- we just bill one code to one 15-minute period.

So that's the premise behind all of this. It's just something that needs to be changed, and I think it's going to take a while at the national level. But I think we -- the Therapy TAC need to address it at the state level this year.

Because last year, there were code edit pairs that went off 1/1/22, and we continued the entire year to have those denials because it wasn't taken off that Medicaid NCCI list.

MR. LYNN: Yeah. We can --

MR. KERN: This is Chris again. If you have a situation where you're questioning

something, I want to encourage you to continue to follow the current process for appeals and reconsiderations with United. However, you're more than welcome to reach out to us with a specific instance, the claim example, and we'd be happy to take that back and evaluate and provide you a full response back.

Sorry, Dale. I didn't mean to interrupt you.

MS. MARSHALL: And, Dale, I think what we need is we need from each MCO what -- are they loading both the CMS and the Medicaid NCCI edit in their system? Are they using both?

MR. LYNN: Yeah. The Medicaid -- the state code is what they should be -- NCCI edit is what they should be loading in our case, I think. Don't you agree?

MS. SAGESER: So are you asking -- Pam, just to clarify, are you asking for us to go down through each one and ask which ones they're using, like asking United: Which ones are you using? Are you using both or this one?

MS. MARSHALL: Yeah. Yes.

MS. SAGESER: Humana, which one are you using?

MS. MARSHALL: Because we can't tell -- those of us that are therapy providers, we can't tell what -- kind of what we can or can't do. Like, which edits?

Because the whole time -- I thought two years ago, we were just loading CMS NCCI edit, not this -- because you can't even -- like, that whole Medicaid NCCI edit chart is a mystery. Who knew that even existed, you know? And it took a lot of digging to even find out that existed.

MS. SAGESER: So the question is: Are you using CMS or Medicaid?

MS. MARSHALL: Or both.

MS. SAGESER: Or both. Okay.

MS. MARSHALL: And then the TAC needs to approach it going to DMS and, you know, giving a suggestion of the code -- the therapy code pairs that we need removed, that are removed on CMS and should be removed on Medicaid.

MS. SAGESER: Okay. I think we

have representatives from most of the MCOs on the call today. Is that something, Dale, we can just go through and -- and first off, the ones who are listening that are with the MCOs, do you have that information? I see that we have, you know, Aetna, Anthem, WellCare, Cigna -- let's see -- and then Passport.

So do we want to go through there? Dale, do you want to go through there and ask these questions, see if they have a yes or a no? Or if they don't know, then they can get back to you.

I think you're on mute, Dale. Sorry.

MR. LYNN: I'm sorry. I was muted.

Yes. Can each of you representatives speak to that?

MR. OWEN: And this is Stuart Owen with WellCare. I just want to note I don't know exactly, but I'm reading from our contract what we're required to do, our contract with DMS. And it says, "Claims need to be edited using all components of the CMS mandated National Correct Coding Initiative." So that's what we're obligated to do per our

agreement with DMS.

MS. SAGESER: Okay. So you're using the national. WellCare is. Okay.

MS. MARSHALL: Well, I think it's not actually -- I'm just saying this thing is -- this secret Medicaid NCCI chart, it's not a secret, but it's a secret to providers, I think, because it's not published or discussed or talked about. It's just an edit that ends up being loaded.

And, you know, even at the national AOTA reimbursement level, I'm not sure they were aware that edit list existed three -- I think we started on it three years ago. So the specific thing: Are both CMS and the Medicaid NCCI edits loaded in your system? It's two different lists.

MS. SAGESER: Okay. I think Jonathan is on here. Jonathan is with Kentucky Medicaid. Is this something you can help us with?

MR. SCOTT: I'm sorry. Could you repeat that?

MS. SAGESER: Is this something that you can help us with, on the Medicaid

NCCI edits that the providers are not aware of, and clarify what edits we need to have updated in our system for -- and which ones that the MCOs are required to have?

MR. SCOTT: No. I need to defer to my colleague Justin Dearinger on that. I don't know if he's on here today.

MS. SMITH: I don't think he's on, Jonathan. It's Pam. I will -- I'll take a note for us to take this back.

MR. SCOTT: Yeah.

MS. BICKERS: Is anyone from policy on today?

MS. SMITH: Scanning quickly, Erin, I don't see -- I don't see anybody. I don't know if anybody else -- Jonathan, if you see anybody. But I'll --

MS. TOLL: Pam.

MS. SMITH: I'll take a note to put that back -- oh, Cynthia. Okay. Sorry. I didn't see you.

MS. TOLL: Yes. I'm on. I have had computer problems this morning. I just got on.

So exactly what is the question you need

to have answered?

MS. SAGESER: So we are trying to clarify what NCCI edits are to be used with the MCOs and their -- I guess, there's this Medicaid MCO -- or Medicaid NCCI edit that is going around, but providers don't necessarily know what all edits are on there to make sure our systems are updated.

And the other question is: Which M -- the MCOs, which ones are they to follow? Are they to -- because their contract states they're to follow -- well, WellCare stated their contract said per DMS, they were to follow the CMS NCCI edits. And then, you know, I think, as Pam Marshall stated, there's -- you know, certain MCOs are doing a mixture of both, and it's very confusing for the providers. Correct me if I'm wrong, Pam, on that.

MS. TOLL: I don't really have an answer to that question for you. I really don't, but I will take this back. But in most cases, we follow everything with any -- fee for service is going to follow everything with Medicare. So I will find out because I

don't know about the MCOs, and I've just started this job about two months ago.

So I will take this back to -- and Kelly is sick. She's at the doctor today. She would be on here, too. So if they can't -- we'll get you an answer for it. It's the NCCI --

MS. SAGESER: NCCI edits. The question is, there is supposedly this Medicaid NCCI edit that is floating around, but providers don't have that information.

MS. TOLL: Got it.

MS. SAGESER: So is that truly the DMS NCCI edits, and maybe Medicaid just hasn't been updated as fast as, you know, the CMS updates theirs? That might be the question.

MS. TOLL: Okay.

MS. SAGESER: And then what is your time frame on getting that back to us? Because I know we --

MS. TOLL: I will talk with someone today. I will find out something for you today and try to get you an answer.

MS. SAGESER: Okay.

MS. BICKERS: I believe Justin just joined, if he could address that. I'm not sure if he got the whole question.

MS. PARKER: Look, this is Angie with Medicaid. I'm Angie Parker. If you're talking specifically what the MCO contract states, it says, "Claims need to be edited utilizing all components of the CMS mandated National Correct Coding Initiative." Now, if there's more to that, then Justin may be able to answer.

MS. MARSHALL: I think that it's confusing because many people don't -- at least providers or people working on reimbursement don't actually know there are two different lists that CMS has. One is the CMS Medicare NCCI edit, and that's largely what everybody goes by.

But then there's an additional listing. It's on a spreadsheet deep within CMS' website that is difficult to know it is even there, and it's called the Medicaid NCCI edit.

MR. DEARINGER: Hi. This is Justin Dearinger. Sorry for the confusion, and I

know it is confusing. We have those NCCI edits. I know we're working on those. I don't have a time frame.

Our coder is sick, and she's the one that's been working on those. So as soon as she gets back from her illness -- I'm assuming one day this week -- then I'll let you have an update on exactly where she's at. I think she was about done, but I don't know exactly for sure.

And those do come from Medicare. They're not something that we make up. I mean, those are something that come from them. They're the source of that. And, again, there's a little confusion on exactly which ones they are or what they're called or whatever.

But those come from Medicare. We review those, put those in place, put those in the system, and then usually put a notice out on the web page. And I'm not sure exactly. Forgive me for not knowing exactly how they've done that in the past, but I know we had planned on making a notation on the fee schedule and then sending out some kind of

provider notice through the MCOs.

MS. SAGESER: Okay.

MR. DEARINGER: So you all will know as soon as it's updated.

MS. SAGESER: So, Justin, I think what she was saying is CMS has two NCCI edit charts. One is Medicare. One is Medicaid. But Kentucky Medicaid follows Medicare, not the CMS Medicaid, is what you're stating.

MR. DEARINGER: No. Both essentially come from Medicare. I'm not sure exactly which one. I'd have to find out, so let me find out. And I'm not a --

MS. SAGESER: Okay.

MR. DEARINGER: Digging a little too deep in the coding for me to know exactly.

MS. SAGESER: Okay.

MS. MARSHALL: We just may need it clarified from DMS as well, Renea, because this has been a -- it's kind of a surprise. Because most people nationally, even in our therapy world -- you know, speech, OT, or PT even at the national level -- follow CMS Medicare's NCCI chart. That's what they

think.

So as we've been successful getting coded at pairs off of that, you know, terminating it off that list, it still exists over here on this -- I keep saying secret Medicaid because nobody that I know talks about that NCCI list. You know, those code pairs are still on there.

So while you think, oh, great, we've accomplished something and got these pairs off that allow us to bill what we do and allow us to, you know, do this one-to-one therapy -- and we're not doing anything wrong. We're not upcharging, upcoding. And it exists over here, and we still can't bill what we do.

So it's like holding a therapist's hands behind their back and saying, nope, you can only bill these -- you know, unless you want to fight an immense amount of sending medical records in and claims disputes, which that's not fun. Because the volume of what's there normally when you serve Medicaid is so high, it's hard to even manage the normal problems, much less having all of this on top of it.

It's just a huge administrative issue.

MR. DEARINGER: Yeah. Let me get some more specifics so that I can have some better answers for you all. And, again, it may be when our coder comes back because she was the one assigned. And she's been working on it, and I thought she was just about done. So she'll have more specifics on it, and I can get it back to the TAC if that sounds good.

MS. MARSHALL: Sure.

MR. LYNN: That would be good, Justin. Appreciate it.

MR. DEARINGER: Awesome. You're welcome.

MR. LYNN: Yeah. The edits are pretty hard to deal with, and it's not really a secret list. It's one that's just not very well known about.

I guess we're on to new business, and that is what I spoke of earlier, some concerns by providers having difficulty hiring speech, OT, and PT because of the low Medicaid reimbursement for services. And that's a real thing. It's just like the

First Steps issue, the low reimbursement.

And I know that Medicaid is wanting to put occupational therapy more in the mental health area and helping out with that, and we can't hire occupational therapists because of the low rates.

MS. SAGESER: I do think it should be noted that our rates have not been increased in over 15 plus years for a straight Medicaid fee for service, very -- you know, very similar, small increments of increases. Some years -- I think 2015 was a decrease.

So with -- you know, what -- and I don't know if it's a TAC position or not, and so that's where if Medicaid -- we're trying to figure out, like, does the budget have to open. Is there something -- we know that there are funds right now at the state level to potentially increase here for the fee-for-service schedule, and I didn't know if anybody was on that could maybe help address some of that.

MS. MARSHALL: Renea, I actually did a study on a spreadsheet. And over the

last -- gosh -- three, four years, we have some codes, and some of our decreases have been as high as 13 to 14 percent. And I know they're pricing the Medicaid fee schedule off Medicare. So as inflation rises, we've lost anywhere between 9 and 14 percent overall.

MS. TOLL: I'm not real for sure how to answer this question for you all, but I do know that I have been working on PT and occupational fee -- the fee schedule for 2023. And I know that as I've looked at the rates, some of the rates have increased. I don't know that all of them have. I can't pull it up in front of me right now because I don't have it. I've sent it on to Kelly and Eddie to look at it.

I think that there may be some adjustments on both of them, on the amount of -- for each additional code, there may be an increase, but I'm not for sure. So that's something that I'll need to take back to Kelly as a question or Justin. Because I see he's left the meeting, also.

MS. SAGESER: Yeah. I think, you know, we know the mental health department is

currently asking for a 30 percent increase. I don't think we're asking for a 30 percent increase, but I think that a significant increase, since there hasn't been one over 15 years with everything that's gone on.

Most of us that are business owners on here are losing providers faster than we can hire them, and we're not able to replace them. So our waiting list -- I know my waiting list is in the 3,000s at this point.

MS. TOLL: Okay. So mental health is asking for a 30 percent increase?

MS. SAGESER: Yes.

MS. TOLL: Okay. All right.

MS. SAGESER: We're asking for maybe -- we would like to see at least a 10 percent. That would be nice across the board with our fee for service. I'm sure a lot of us would want more than that if possible.

MR. LYNN: Mary, did you have a question?

MS. TOLL: Well, according to what -- when I took the position, according to what I've been told, I do know that there -- I was told that there hadn't been an

increase. So I think you're very correct in that manner, but I don't want to answer something and tell you something that's incorrect. That's why I need one --

MS. SAGESER: I appreciate that.

MS. TOLL: One of either -- one of them. I can take the question back to them and get back with you, but I want a specific answer to that question. Because I know I've worked on the schedule -- or the fee schedule, but I haven't seen -- you know, I don't know -- I haven't seen it in the past.

So I need to know, you know, what went on in the past versus what's going on now. And I don't know that there's a 10 percent or a 30 percent or whatever there might be on any of it, but I will find out for you.

MS. SAGESER: Yeah. Now --

MS. TOLL: At this point -- and this is just because nobody wants -- nobody wants to take the positions because of that issue; right?

MS. SAGESER: I mean, that's the big piece. We're not being competitive. We're not able to be competitive in the

market right now with Medicaid, with pediatrics, you know.

MR. LYNN: Right.

MS. SAGESER: People are leaving and joining the SNFs and the hospitals and schools because we're just not able to be competitive in our field.

You know, we are into 2023. Do you know when we're going to expect the 2023 fee schedule?

MS. TOLL: I -- again, I know that everything has been worked up. I know that -- I know that when we went with vision, dental, and everything that has the -- the new stuff that has gone on has put a hold on a lot of stuff.

Like, I can't exactly tell you that. I know that they're being prepared. I know that we're working on them, but I can't answer that question either. I know I'm not much help. I'm just on here to try to get your questions basically and make sure that I get them back to -- unfortunately, Kelly is sick. So she would have been on here, and she is the person that can answer any of

these questions. I will ask, but I do not have an answer at this point.

MS. SAGESER: Okay. If you could email Dale a timeline for when the 2023 -- and I'm sure all the MCOs are also asking for that, when that's going to be updated, that would be great.

MS. TOLL: I will. I will take care of that.

MS. SAGESER: Thank you.

MS. MARSHALL: And, Renea, for the record, a majority of the codes -- while there are a few that have gone up, majority of our codes have gone -- will have gone down another three, four, four and a half percent overall. So we're expecting a big decrease again.

MS. BICKERS: And, Cindy, this is Erin Bickers. If you want to send that information to me, I'm happy to email it out to the TAC.

MS. TOLL: Oh, that would be great. I didn't -- and Eddie, of course, they -- Eddie should have been on here, also, but they all have other meetings scheduled around

this one. So -- but Kelly -- Kelly apologizes to you folks. She said that this was -- you know, she had scheduled this meeting to be there, to be able to answer all these questions, but she's been sick for a week. And I think, you know, she had a doctor's appointment this morning, so she could not be on it. But yes, thank you, Erin.

MR. LYNN: Thank you, Cindy. Appreciate it.

MS. TOLL: Uh-huh.

MR. LYNN: The second item on new business is the Medicaid PA team is trying to require physicians' signatures on plan of cares when they have an active physician's order in our area and not happy. This is not written in regulation but rather an interpretation of the words "in collaboration." It's something that Pam spoke of earlier.

So does -- what are your thoughts on whether this is just an interpretation, or does the physician's signature need to be on the plan of care?

MS. MARSHALL: And, Dale, to be clear, we're recommending -- and I think the doctors would agree. We're recommending that that requirement be removed, that the PO has a -- the physician order has a timeline that if we're resubmitting for additional visits, we have to have that PO signed within that timeline. And that serves as the doctor's acknowledgment that I agree this child's plan of care should continue, and this therapy should continue.

And that should serve as the -- you know, because what's happening right now, it's a pattern of these are the most vulnerable kids on straight Kentucky Medicaid. And, well, a lot of doctors' offices, they're saying they're so busy just managing sick kids right now, that they honestly cannot take time to do all these administrative tasks.

And I've talked to groups that are very big in our area, and they're not happy with it because it's just an extra thing they have to do. And we have to put the child on hold while that -- we're trying to get that signed

plan of care.

MS. SAGESER: Is there anybody on Medicaid -- I know a lot of the Medicaid individuals are not on this phone call today, which we really need. But is there anybody on this phone call that can answer this question?

MR. SCOTT: Is this a new requirement?

MS. MARSHALL: It's been new as of 2022 enforcing it. We've been told it's not new, but it's the PA team, you know, at DMS. They're enforcing it in 2022. I can't -- I don't know the exact date of last year when that started being enforced. But they started, you know, not approving without that signed plan of care or saying that we've got to have the signed plan of care.

And we've asked, well, where is this? And I think it was actually stated to us that it was Charles Douglas that was the one interpreting those words "in collaboration with."

So we're just asking that DMS look at this in regulation because it does not say

signed plan of care by a physician. It just says the words "in collaboration with."

MS. BICKERS: Dr. Cantor has her hand up. Sorry, Jonathan.

MR. SCOTT: Yeah. I was just going to say if you could get me that in writing as well, I'd like to see your paper trail on that, and we could take that under advisement.

MR. LYNN: Dr. Cantor.

DR. CANTOR: Oh, thank you. I was just going to add that we eliminated that request as part of these therapy prior auths, having that signed plan of care from UnitedHealthcare. Thanks.

MS. SAGESER: That's good.

MS. PARKER: If you're -- this is Angie with Medicaid. If you're talking about fee for service strictly, then as to what Jonathan had brought up, it would help to know who you've talked to with the Medicaid fee for service on this.

So if you can -- you can either send that to Jonathan or to Erin and Kelli, and we can get that to the right personnel to

review.

MS. TOLL: I will also step in on that again. The clarity on that I'm not for sure about, so I will -- I will get your questions answered and get back with you.

MS. SAGESER: Is there other -- the MCOs that are on, do you want to go through -- is there any other ones that require that, Pam? No. It's just the fee for service at Medicaid.

MS. MARSHALL: Yep. Yeah. They're the only ones.

MS. SAGESER: Okay. All right. Thank you.

MS. WILSON: While we're on the traditional Medicaid issue, can I bring up something? We had talked about this last time, about the 48 hours signed. Pam, I thought you had thought that it was 48 business -- 48 hours for business days, but we are getting calendar days on our end.

MS. SAGESER: It is calendar.

MS. WILSON: Yeah. So Cynthia responded to an email, and she said the regulation states that it is 48 hours. It's

not -- it's based on calendar days, not business days. So that's a problem.

MS. SAGESER: It used to be the same day, and I was audited by Passport. I think it was 2016 or '17. And I went back, and we were able to change it to 48 hours. That was one of the things that we were able to accomplish.

But I still -- I agree with you. Like, it is a burden, especially on a Friday afternoon, if you have an evaluation that comes in at 4:00 or 5:00. It's really hard to do that with -- as a mom of five kids so...

MS. MARSHALL: And then we're asking our staff to work on a Sunday when that is not part of their workday. That's not part of their schedule. And we actually have it in writing -- and I'm going to have to go back and find out -- that we were told business days.

MS. SAGESER: It is in the regulation.

MS. MARSHALL: I mean, I'm sorry. I said that opposite. We were told -- yeah.

We were told business days. So if you had a 4:00 eval on a Friday, you actually have till Tuesday at 4:00.

MS. SAGESER: It is a KAR regulation that says 48 hours, and it was not clarified business days. So I do know that. But that is something -- correct me maybe Jonathan. That is something that Medicaid -- that DMS could change; correct?

MR. SCOTT: I am looking up the exact citation for you. Okay. So here's what -- here's what you all can hang your hats on. 907 KAR 3:010, Section 2(4)(b) -- 4(b)(2). All right. So that says 72 hours, and that applies to all providers.

MS. SAGESER: Okay. So tell me that --

MR. SCOTT: That is our interpretation. It's a 72-hour, and so I do --

MS. MARSHALL: Can you state that KAR again?

MR. SCOTT: Yeah. And I'll also say I drafted the change to 48 a couple of years ago. We have gone beyond that, and

we're enforcing the provider regulation, which is 907 KAR 3:010, Section 2, Subsection 4, paragraph B, subparagraph 2. And I always forget that one, so sorry --

MS. SAGESER: That is a Christmas gift to all of our staff. You have no idea.

MR. SCOTT: No problem. We are moving to that for all providers, so it's a 72-hour standard.

MS. SAGESER: Okay. So are you going to update the 907 KAR 3 -- the 30? Because that's the one that we were told we had to follow.

MR. SCOTT: Whoever told you that was wrong.

MS. SAGESER: Okay.

MR. SCOTT: The provider regulation applies to everyone. It's a 72-hour standard. So if people --

MS. WILSON: When was that in effect? When was the 72 hours in effect?

MR. SCOTT: It's -- that is what the regulation states, so that's the floor. It's a -- it applies to all providers. We -- so this regulation supersedes -- and I've

forgotten your all's -- you're in Chapter 8; right?

MR. LYNN: Yes.

MR. SCOTT: It supersedes the Chapter 8 reg. It's an all-provider reg.

MR. LYNN: That's a relief.

MR. SCOTT: And that's a new interpretation that we have started employing in the last just couple of years.

MS. SAGESER: Well, that would have been nice to know.

MR. SCOTT: So if anybody gives you trouble on that, just send them to us.

MS. WILSON: Yeah. That was going to be my question. Who do we contact exactly for problems with that?

MR. SCOTT: You can email me. You can email Veronica. You can email -- it is Veronica's interpretation that was shared during a TAC or a MAC meeting. So that's --

MS. WILSON: Do you mind to put your email in the chat for us?

MS. SAGESER: We just had an email from the State because we just asked for clarification again, and we just had an email

because -- I think it was in December that said we were still 48 hours.

So, Jonathan, I'm going to find that email, from who that was with at the State, forward that to you just to make sure that you "cc" us in writing that says that we are good.

MR. SCOTT: Yep. Sure.

MS. DEROSSETT: Now, to clarify, is that for all notes, or is that when you were talking eval?

MR. SCOTT: That is -- that's a health record.

DR. THERIOT: Everything.

MS. BICKERS: And the TAC is always willing to email -- this is Erin, Kelli and I -- and we can always forward those emails if you don't have anyone else's email.

MS. SAGESER: That's exciting. Good news.

MR. SCOTT: That's my email address.

MR. LYNN: That's good news, yeah.

MR. SCOTT: I can't provide that for you very much, so I'm happy to -- happy

to help.

MS. MARSHALL: So -- and just to clarify, then, we don't say whether that's business days or days? It's just 72 hours period; correct?

MR. SCOTT: So that's where we get into a little bit of a fuzzy situation because we have to jump to KRS Chapter 13A, which is their definition. So when you go over five business days, then you no longer count the weekends. No. That's not right.

So I think hours -- we're influenced by KRS Chapter 13A, and I have not seen that. But I think when you're at hours, you do count the weekends. When you're not -- when you're looking at days, you have to go over five days.

So five days means a week but -- so, like, if it said seven days, then you wouldn't count the weekend. So generally it means business days up to, I think, calendar -- up to, I think, 30 days or something. There's a wrinkle to it in KRS Chapter 13A that I just haven't seen for a couple of years.

MS. MARSHALL: Well, I just think we need clarity because it's really that Friday to the next week problem. Because none of our salaried staff work Saturday or Sunday. So 72 hours, then, would mean if Monday is a super busy day for them, how are they getting that documentation done from late on Friday if 72 hours is Monday? You see what I mean?

MR. SCOTT: Sure.

MS. MARSHALL: So we really need to know. Because we were told in writing we could go till Tuesday --

MR. SCOTT: That's right.

MS. MARSHALL: -- on that documentation.

MR. SCOTT: If it's a Friday to Tuesday. So, like, you could have a Thursday to Monday issue or something like that but --

MS. MARSHALL: Right.

DR. THERIOT: Well, what about a long weekend? Like, next weekend, it's Martin Luther King Day, so what about then? What happens then?

MR. SCOTT: I'm not sure if we have

the ability to set the policy for that because it's set for us in statute. So I don't know if we can skip -- I think, you know, I'd have to look into whether we can skip Sundays and holidays, but it's the --

MS. MARSHALL: It just needs to be clear because when we're audited, we want to know that we're following the rules correctly.

MS. WILSON: So are we saying it's 72 hours calendar days or working days? I'm still confused.

MR. SCOTT: So it's -- I think it's 72 hours, just 72 hours. That's the standard. But, I mean, if it was 72 hours of working hours, that would be like, you know, two or three weeks or something. So we'd have to -- we couldn't do it that way.

MR. LYNN: That's 72 hours from the time of service.

MR. SCOTT: Right.

MS. WILSON: Okay.

MR. LYNN: So that makes sense. So it still puts you in a situation on a long weekend, but it's better than the 24 hours we

used to have.

MS. SAGESER: Yeah, which then moved to 48 so...

MR. SCOTT: There was one provider type that had the same day, so we've --

MS. SAGESER: Well, we -- yeah. We used to have the same day. That was the regulation. It actually wasn't 24 hours. It was same-day documentation. That was prior to the change to the 48.

MS. MARSHALL: And that was very unrealistic.

MS. SAGESER: Yeah. It was -- yeah.

MR. LYNN: That was not doable. So yeah, that's good news.

We can move on to the third item of new business, but the individual that asked me to put this on the agenda said that they no longer need to discuss this on the agenda.

MS. SAGESER: No. It was just an edit update, and they said it was going to be fixed, I think, January 18th. So it should be good.

MR. LYNN: Okay. I would like to

circle back to the NCCI edits briefly. And, Pam, would you mind to clarify what that actually costs a therapist as far as reduction in --

MS. MARSHALL: Sure. Sure. So, I mean, it obviously depends on how many units which, just for clarification on this call, typically, an OT or a PT would see a child for about an hour, sometimes 45 minutes.

But let's just take the hour example. If you billed two units, which would be 30 minutes of one code and two units of another code and if they were an NCCI edit pair, they would only pay two units and not pay the two units with the 59 modifier. Because the 59 modifier indicates the Column 1/Column 2 code pair set. And so, you know, it's a claim edit that then denies half of that payment.

And, I mean, for example, our practice, we have thousands of claims involved in this and, you know, it takes a lot to get through -- it's very time-consuming to try to submit medical records and claim denials and all that on it. We even have some MCOs that have written us out of that edit. However,

we still get denials.

So it's -- I thought we were, you know, in a winning situation, getting some of these pairs off the CMS Medicare fee -- or NCCI edit chart, getting it off as of 1/1/22. But it didn't help because we kept getting all last year the same denial patterns.

And they're not necessarily denials, but the denial is the bundling. So, you know, you essentially are getting paid half, 50 percent. And we -- I mean, there's nobody that can put on the service for that. We can barely put the service on for what we're being paid.

MR. LYNN: Yeah. And the case is you're documenting those CPT codes because that's what you're actually doing in therapy. You may do therapeutic activities for 15 minutes and then maybe feeding for 30 minutes and maybe therapeutic exercises for 15 minutes.

MS. MARSHALL: Right.

MR. LYNN: And then they pay fees --

MS. MARSHALL: It's gatekeeping how

we bill, and it's the hardest thing, as the leader of our company and many, many therapists, trying to educate them on coding and billing. Because we don't have a coder; our therapists bill. They put those codes in.

And they only have a very small set of codes anyway that they bill. Like, in terms of treatment, it's less than ten codes for sure. PT is probably five that they use in pediatrics. And it's just not a lot of code pairs or sets they have to choose from.

And we're basically saying, okay, for this pair, you've got to do this. And for this pair, you've got to do that. And it's just -- I mean, it's wrong from a standpoint that they have master's and doctorate degrees. They should be able to bill what they do.

And there's no reason for it because there's not a -- there's no upcharging. Like, that was the basis for that NCCI edit chart, was to prevent people from billing lots more codes, like coders and, you know, billers on the back end upcharging what was

happening in that visit or that surgery or that event. And that isn't what we do. We only do one code per 15 minutes.

So, you know, it's frustrating because it's basically, like, oh, we don't care you did a great service, and you did great documentation and did great billing. We're only going to pay you half for that. So it doesn't make any sense.

MS. DEROSSETT: Pam, to clarify, did you say when you put the modifiers on, that you're still getting denials?

MS. MARSHALL: Yes. Yes. That's what happens now, especially -- you know, I've met with higher-ups in Cotiviti, which not all MCOs use Cotiviti, but many of them do now. And that's a third-party company that runs the claim edits. And, you know, it's all about saving money. It's all about putting your arms around that bundle of money and keeping it.

And so I know that for people that aren't providers and aren't in it on this side, you don't understand that, that I also understand the business side of Medicaid,

that you have to have claim edits. You can't just have money walking out the door that you shouldn't, you know, that Medicaid -- we have to be responsible with Medicaid dollars.

But the flip side of it is it's just a game to keep our money and, you know, there are a lot of times it's difficult even to get paid interest. So we feel like a bank. We feel like we're loaning the MCOs all this money while they just sit on our claims.

So it's frustrating because we don't get paid enough to have a reserve to have that high of an AR problem. And when it's something that we didn't do anything wrong like these edits -- you know, you think, oh, we're doing the right thing. We got it off the NCCI edit on a national level, yet we're still experiencing it. And there's not a logical reason why. It's just because they can. They can deny it and --

MS. DEROSSETT: Right. And then edits are also cross-disciplined. So if you have a PT and OT billing the same code, then those issues -- you can't get reimbursed for both.

MR. LYNN: That's true. If you have a PT that bills therapeutic activities and an OT that bills the same code on the same day, the one that bills it first gets paid.

MS. DEROSSETT: That's what concerned me. If they're putting the edits in and still getting denied, that's concerning.

MR. LYNN: Right. Is this something we should take to the MAC and discuss?

MS. MARSHALL: Yes, please. Yes, please.

MR. LYNN: Okay. Are there any other issues from any other TAC members or the public that's on here?

MS. WILSON: I have two things, Dale.

MR. LYNN: Okay. Thank you.

MS. WILSON: The first thing is for traditional Medicaid and Aetna Medicaid, the auths that we get cannot overlap. So, like, if we need to add a new service -- for example, we're seeing the child but then they

start choking on their food and we need to add feeding, the feeding code wasn't initially on the auth perhaps; okay? And so that code needs to be added.

But what we have to do is we have to wait until that first auth expires at 90 days before we can add a new service. So we can't bill for the feeding code now even though we need to see this child for feeding before the 90 days expires.

So, basically, it's like we're not going to pay you for that service until that auth is up, and you get a whole new one. And that's traditional Medicaid and Aetna Medicaid that's happening with for us.

MS. MARSHALL: And, actually, Kresta, this goes back to -- we had these discussions in 2014, '15, '16, is prior authorizations from Medicaid should be given to the visit, not to the code.

So DMS always supported that, and I want to know in writing if -- Kresta, if you're experiencing that. All MCOs and DMS should authorize to the visit. Like, an OT or a PT or a speech therapist should be able to bill

whatever code is on the fee schedule to that patient for that visit. Because different problems do arise, and this is true on the adult side, too.

Again, it's just gatekeeping what we can and can't bill, and that's -- that's really wrong. We should be able to bill whatever is on that fee schedule for that visit. If we had to make a splint and we had to, you know, bill that code, we should be able to do it and not have to stop and get it added to a PA. It's wrong to have codes specific to the PA. It's a visit. It's an event.

MS. WILSON: Yes. And I agree. If it's on the fee schedule, they're saying that this is a qualified service. This is something that we are willing to pay for. And like you said, they've approved a certain number of visits. Then yeah, it's definitely micromanaging, you know, and certainly limiting what we can do. And it just -- it doesn't make any sense.

MS. RISNER: Hey, Kresta. This is Krystal with Aetna Better Health. If you have some examples of situations in which you

had, you know, been turned down or say that you have to wait 90 days, can you forward those to me and let me get with the PA team and address those?

MS. WILSON: Sure. Can you put your email in the chat for me?

MS. RISNER: Yes.

MS. MARSHALL: And, Kresta, what payors are you experiencing that with?

MS. WILSON: Just traditional Medicaid and Aetna Medicaid.

MS. MARSHALL: We don't experience it, so that's why I'm surprised to hear you experience it.

MS. WILSON: Yeah. It's like they pick and choose things, yeah.

MR. LYNN: Yeah. We've not -- in our practice, we've not experienced that either.

Mary Hass, you have your hand raised. Would you like to -- do you have a question?

MS. HASS: Yes, please. Thank you, Dale. I appreciate y'all allowing me to speak on the issues as it relates to the therapies and the two ABI waivers.

We are kind of in a flux right now because both API waivers are being renewed and the way the therapies will be transferring over to the state plan. We are losing many of our very skilled and experienced therapists because of the low reimbursement rates which, you know, I've heard everyone address earlier.

But it's a real concern because with the cognitive rehab, that's usually led by a speech therapist. And that's one of the lowest rates because they're only paid per episode per -- what I'm being told by the speech therapist.

So I wanted to bring it to the TAC, make you aware. We addressed it in the Behavioral TAC which I sit on. And so, anyway, just wanted to bring it to your attention. But it will be a real concern because I'm hearing you already talking about not being -- serve people, waiting list. And I think our problem will only be exasperated (sic) when it goes to the state plan, our therapies go to the state plan.

So thank you for allowing me to express

my concerns on that.

MR. LYNN: Thank you, Mary. Appreciate it. So --

MS. WILSON: Hey, Dale. I have one more thing real quick.

MR. LYNN: Oh, okay.

MS. WILSON: This is also for Aetna. I'm just curious if anybody else -- you all are experiencing this. It's a code that maybe is not super common, but it's one that we can bill. And, Dale, I think we talked about this.

It's 96112. It's developmental test administration. It's an assessment of fine and gross motor, language, cognitive level, social, memory, and/or executive functions by standardized development instruments when performed by a physician or other qualified health professional with interpretation and report. That's the definition of that code.

Aetna does not pay that. They're saying that it's a mental health code. So I'm curious if anybody else is experiencing that. It kind of just depends on the company, you know, insurance-wise on the commercial side

whether or not they pay that. But it is a code that we, as therapists, can bill as long as it's a standardized, you know, assessment. So I'm curious if Aetna has anything to say about that or if it's -- why they're saying it's mental health.

MS. RISNER: Without having examples to look at, I wouldn't be able to advise you as to, you know, what kind of denials that you're picking up on those or seeing. You know, it would be something I would have to take back and research and try to look in to see what edits are set in place that is actually causing that denial.

So if you can also send, you know, some of those examples over to me, I'll take that back, and we'll figure it out and get it answered for you.

MS. WILSON: Okay. Sure. Thank you.

MR. LYNN: Yeah. We have not seen any denials on that code in our practice, and it's not a mental health code. It's developmental testing.

MS. DEROSSETT: Dale, we had one

issue. Is it okay if I go ahead and bring it up?

MR. LYNN: Sure.

MS. DEROSSETT: My pre-auth department, what they said is they were having some issues with Medicaid Humana, maybe Healthy Horizons. She said that -- especially with speech. She said they're only giving, like, four visits, but they'll give, like, 26 weeks or six months. But every fourth visit, you still have to go in and resubmit. And I didn't know if anybody else was having that. They just asked me to bring it up.

MR. LYNN: I'm not aware of it. Who was that? What insurance?

MS. DEROSSETT: Excuse me?

MR. LYNN: What insurance was it that was --

MS. DEROSSETT: She said Medicaid Humana, maybe Healthy Horizons. Does that sound -- that's going through eviCore. So PT and OT is not an issue. They usually get, you know, their 26 weeks one time a week maybe, but the speech is where we're having

the issue.

MS. MARSHALL: I can speak to this. I think, Dale, you can, too, that we addressed this with eviCore and a different MCO back in 2016 when they tried to do this. And I call it turning off the switch to therapy. They were giving a blanket, like, four visits. And I would challenge their -- you know, what -- the criteria that they're using.

Because if the criteria in your notes meets medical necessity, then they really can't do that. They can't give those blanket four visits or six visits for a 26-week period kind of situation. I mean, that should not be allowed.

And if -- InterQual was the guidelines they were using back then, and I would imagine it's still the guidelines they're using today. So you just might have to produce those examples and dig into that a little bit.

But Dale and I were on a call back then, and I feel like there were 18 people on that call. And we had, you know, that -- that

third-party PA company was on the call, eviCore.

MS. BICKERS: This is Erin with DMS. I just had a quick question. When you guys are experiencing some of these issues with the individual MCOs, are you reaching out to your provider rep or utilizing the Department of Medicaid provider complaint process?

MS. MARSHALL: We are. We use it frequently.

MS. BICKERS: Okay. I just wanted to make sure everyone was aware of those two options. If you're going through your provider rep and not getting any satisfactory outcomes, that there is the provider complaint process through Medicaid, where we can kind of reach out and try to help figure out what's going on through that.

So I just wanted to make sure everybody was aware of those processes, especially if it's, you know, one particular MCO that you're finding you're having issues with or things of that nature. So I just wanted to ask that quick question.

MS. WILSON: What -- what's the provider complaint that you're referring to?

MS. BICKERS: So the provider complaints -- DMS has a process where if a provider is having issues with certain MCOs with certain issues, we have a provider complaint form that I can send you. It's just a PDF form, and there's, I believe -- and, Angie Parker, correct me if I'm wrong, but I think there's four DMS staff that have the MCOs broken up, and they can send that over for review.

So that way, if you're reaching out to your provider rep with the MCO, and you're either -- they're not getting back to you or you're not getting the answers, it gives DMS a little bit of opportunity to reach out on the provider's behalf to help try to figure out what the issues are.

And so I can also send you, like I said, that link to that PDF form. I have a lot of providers that send that to me, and I send it over. Or I believe I should be able to send you the emails to who handles what MCOs. So I just wanted to make sure you guys were

aware of that process as well.

MS. WILSON: That would be great. How are you going to send that to us?

MS. BICKERS: I'll send it to you via email. I'll usually have follow-up emails after every TAC, and so I'll make a note of that, to send that over to you guys as a whole.

MS. PARKER: And, Erin, if I may, I just would like to add Jeremy Armstrong-DeRossitt is the branch manager over that area and if he would like to add anything to that. But yes, we do ask that you do try to work with the MCO first. But I will also defer to Jeremy and see if there's any additional information he would like to add regarding provider complaints.

MR. ARMSTRONG: Absolutely. Thank you, Angie and Erin. Good morning, team and all attendees. Just to confirm that we do have the provider complaint process. However, instead of providing an individual name that's assigned to the MCOs, I would prefer that the actual complaints be submitted through the inquiry box that is

monitored by staffing under me. So that way, they can appropriately assign those out to the MCO staffing that they're assigned.

But that way, everyone is aware of a specific inquiry box email contact and the form that will be provided by Erin or someone from my team. If you actually reach out to that inquiry box advising of a provider issue that you are having, then you can -- typically, what we'll do in the process is refer you all back to fill that out and resubmit. But we'll make sure to provide that information to y'all after this meeting.

MS. SAGESER: What is the -- Jeremy, what's the typical time frame on some of these, you know, issues or complaints?

MR. ARMSTRONG: They do vary. You know, some complaint issues can be resolved within a 30-day time frame, but sometimes some of the provider complaints do go outside of that 30 days. But we typically get the ball rolling and moving with the MCOs and expect a response from our MCOs from the research completed and provider outreach within five days of receipt of that complaint

form, five business days.

MS. BICKERS: Thank you, Jeremy. If you don't mind, send me the inquiry box email. I'll make sure to get that out to the TAC along with the PDF so that they have everything.

MR. ARMSTRONG: Absolutely.

MS. BICKERS: Thank you, sir.

MR. ARMSTRONG: I'll provide both to you, Erin.

MR. LYNN: Thank you, Jeremy. So the --

MS. MARSHALL: It's good to see you, Jeremy. This is Pam. We talk --

MR. ARMSTRONG: It's good to see you, too, Pam. Yeah. We've talked frequently through this process as well. So yes, it's finally nice to see you face to face.

MR. LYNN: So we have two items that we need to vote on to take to the MAC, and the first one is the First Steps reimbursement. So do you want to --

MS. SAGESER: I can make a motion to take that to the TAC.

MS. WILSON: I'll second.

MR. LYNN: All in favor?

(Aye.)

MR. LYNN: And the second item to take to the MAC is the NCCI edits and our concern about trying to have some of our codes taken out of there.

MS. WILSON: Yeah. I'll make a motion for that.

MS. SAGESER: I'll second it.

MS. SACCA: Second.

MR. LYNN: All in favor?

(Aye.)

MR. LYNN: Okay. If there's nothing else, we'll adjourn this meeting.

MS. WILSON: Dale, real quick. Do you need me to get you something in writing about the First Steps issues prior to that meeting? I don't know what the date deadline is for that.

MR. LYNN: Yes. I would like for something in writing, and I'll also write something up about the NCCI edits.

MS. BICKERS: The next MAC meeting is January 26th. So if you could -- and this

is Erin with DMS. I prefer to have those at least a day in advance. So that way, the second the recommendation is made to the MAC and that meeting is over, I can start shooting that out to DMS staff so that we can get you your response back within the 45 days.

MS. WILSON: Okay. Sure. I can --

MS. BICKERS: And, also, just a friendly reminder. Your next meeting is March 14th. I may or may not be with you guys depending on when baby decides to enter the world, so I've been cc'ing Kelli Sheets on all the emails to you guys. So if you could just make sure to include her in any emails moving forward because I'm on the countdown. So I'm not sure if I will get to see you guys next meeting or not.

MS. SAGESER: Last thing, Dale. Did we want to make a motion to take to the MAC a potential for an increase of Medicaid fee schedule for speech, OT, PT for certain Medicaid codes or not?

MR. LYNN: Yeah. We can take that to the MAC as well.

MS. SAGESER: That we're requesting an increase, that due to inflation and everything else this world -- everybody -- it's the same thing everybody else is asking for. It's all my employees are asking for so...

MS. MARSHALL: I -- I have a suggestion, Renea, that you all would actually use spreadsheets with data from -- because if you've got a loss on a code for 14 percent in the last three or four years and you're asking for a 10 percent increase, that's not really helping us.

MS. SAGESER: That's true. Okay. I'm trying to see if we could put that together before the MAC. Can we make a recommendation that we'll present -- or be able to -- Erin, when would we need to give them that spreadsheet if we could work together to get that?

MS. BICKERS: Preferably prior to the next meeting on the 26th. If that's not something you think you can get together, maybe prepare it for a recommendation for the March meeting.

MS. SAGESER: Well, I was just hoping if we could prepare it before the fee schedule came out, that it might get added.

MS. BICKERS: And that could be something that you can make as an ask to the TAC and not necessarily have to make a recommendation. Since Cindy Toll and her crew are going to be working on that, that might be something you can put together and send to us to send over to them to look at --

MS. SAGESER: Okay.

MS. BICKERS: -- and see what they can do and discover. And then if there's -- you know, you're not satisfied with that, you can always make a recommendation to the MAC in March if you'd like. That would be my suggestion since the --

MS. SAGESER: Okay. So Cindy Toll is who we would need to email the spreadsheet to? Because maybe there's only, like, certain codes that we would request an increase versus across the board, you know.

MS. MARSHALL: I think --

MS. BICKERS: You can always email that to me, and I can send it over to Cindy.

MS. SAGESER: Okay.

MR. LYNN: Renea, I think it would be a good idea to reach out to all three of our associations to discuss the fee scale. It impacts all of them.

MS. SAGESER: Yes. We will do that, and I will --

MR. LYNN: Before we go to the MAC with what we are to actually ask for.

MS. SACCA: Dale, I know that they are currently actively working on that from a fee schedule perspective, all of the associations for the state. So those might be parallel conversations that we need to merge.

MS. SAGESER: We have -- because I'm the state advocate for KSHA. There is a meeting tomorrow that we're discussing.

MR. LYNN: One of the -- Zelda, you had a question.

MS. MACKLIN: Hey, Dale. Yes. This is Zelda with Humana Healthy Horizon. Just wanted to follow back up before the TAC ended with Linda on the examples that you may have from eviCore on the speech visits. If

you wouldn't mind sharing your contact information with me, and we can work directly with you to find out what's going on with those auth requests that you are getting back from eviCore with Humana.

MS. DEROSSETT: I can do that.

MS. MACKLIN: Thank you.

MR. LYNN: Thank you, Zelda.

The only other thing we need to vote on is to take the fee scale to the MAC. Does somebody want to make a motion on that?

MS. SAGESER: Make a motion.

MR. LYNN: Okay.

MS. WILSON: I'll second.

MR. LYNN: All right. And all in favor?

(Aye.)

MR. LYNN: Okay. I guess we can adjourn this meeting.

MS. SAGESER: Thank you, guys.

MR. LYNN: Thank you, everyone, for attending. I appreciate all your input.

MS. DEROSSETT: Bye. Thank you.

(Meeting concluded at 9:50 a.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 17th day of January, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR