DEPARTMENT OF MEDICAID SERVICES
THERAPY TECHNICAL ADVISORY COMMITTEE

****

March 12, 2024
8:30 a.m.

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A P P E A R A N C E S

TAC Members:

Dale Lynn, Chair
Elise Kearns
Renea Sagaser
Emily Sacca
Kresta Wilson
Linda Derosset

MS. BICKERS: Good morning. This is Erin with the Department of Medicaid. It is not quite 8:30 and the waiting room is still clearing out, so we will give it just a moment before we get started.

MR. LYNN: Good morning, Erin.

MS. BICKERS: Good morning. How are you?

MR. LYNN: Doing pretty good. It's going to be a beautiful day today.

MS. BICKERS: I sure hope so. I'm over this cold weather.

MR. LYNN: Mm-hmm. Me too.

MS. BRAY: Good morning, Erin.

MS. BICKERS: Good morning. How are you?

MS. BRAY: Pretty wonderful this morning.

MS. BICKERS: I had an extra cup of coffee this morning so I should be good to go and ready.

MS. BRAY: That doesn't sound like a bad idea.

MS. BICKERS: Okay. It is 8:30,

and the waiting room is clear, but I only caught two committee members coming in. So if I missed anybody, do you mind to please turn your camera on or let me know you are here. Sometimes when people come in big groups, I miss you.

MS. DEROSSET: Who do you have?

MS. BICKERS: I have you and Dale.

MS. DEROSSET: Okay.

MS. BICKERS: So I do not hear any other people speaking up so I can keep an eye out as they come in and let you know if we get a quorum.

MR. LYNN: Okay.

MS. BICKERS: I do have a few more people popping in to the waiting room so if we want to give it just a minute longer.

Give me one second. I just got an email from Kresta, and she is having an issue. Let me send her the link and hopefully we can get her right in.

MS. BICKERS: Good morning, Emily.

MS. SACCA: Good morning, everyone. How are you all?

MR. LYNN: Doing good, Emily. How about you?

MS. SACCA: Hanging in there. I'm sure others on this call have experienced the exhaustion post-Disney, which is what I am dealing with after surviving a week of that with three children under seven.

MR. LYNN: Yeah. That and the time change right after it.

MS. BICKERS: You need a vacation from your vacation.

It looks like we have a couple more members coming in so as soon as they get logged in, we should have almost everyone, I think. It looks like Renea is in.

MR. LYNN: Good. Everyone is here.

MS. BICKERS: And Kresta. It looks like she got in. There you guys are. I had to scroll. I can't always see everyone's lovely face.

You have a quorum, Dale, if you would like to begin.

MR. LYNN: Good morning, everyone. And welcome to the March TAC meeting. The first thing I'd like to ask is for the review and approval of the January 9th minutes. Has everyone had a chance to read those?

MS. SACCA: I'll make a motion to approve.

MR. LYNN: Okay. Second?

MS. WILSON: Yeah, I'll second.

MR. LYNN: All right. Thank you.

First order of old business is, once again, a follow-up from the department. The study findings on the OT PT speech fee schedule.

How is that going, Justin?

MR. DEARINGER: Hello. It is going good. We're still working on that. We still have not completed that or finalized that, so that is still in the process. I think we've got all of the data, and we are just trying to put all of

that together and analyze that and come up with recommendations to send to leadership at this time.

MR. LYNN: All right. Thank you.

The next item is the process of getting retro PAs from traditional Medicaid when a member applies for disability and is assigned from an MCO back to Medicaid. Is that process getting any better? Anybody experience that?

MS. MARSHALL: Dale, this is Pam. No. It's not getting any easier. I think Renea is having tech problems, but she may be able to comment, too.

MR. LYNN: I see Renea is on here, but maybe she is muted.

MS. BICKERS: She said she is having some issues hearing so she is working on trying to get that fixed.

MS. WILSON: I chatted her so maybe she will see that.

MS. MARSHALL: The problem with the retro PAs is it's taking a lot of time and energy trying to get repaid. That is

the biggest issue. And the other issue is with the prior authorization, you know, when it switches from fee-for-service Medicaid to an MCO, or vice versa, if it was an MCO, and now fee-for-service Medicaid. That's mostly what it is, it's going that way. Where we had a PA with the MCO, but now Medicaid, you know, just that whole process.

MR. DEARINGER: So Pam, this is Justin Dearinger.

MS. MARSHALL: Mm-hmm.

MR. DEARINGER: When you talk about the process, do you mean just the administrative process itself?

MS. MARSHALL: Yeah. And it's taking a really long time, because we can't be paid until the MCO has recouped and sometimes they are recouping months before we are getting any sort of payment from Medicaid. And it's a lot of claims. Sometimes we've had as much as a year's worth of multiple disciplines. It's just very time-consuming and arduous.

MR. DEARINGER: So we've done a

couple of things to address the situation. The first thing we did was to, kind of, put in, you know, a policy clarification that there only had to be one prior authorization. So I know that was an issue for a little while is that some of the MCOs and fee-for-service, maybe both, were requiring additional prior authorizations if a member moved from one MCO to traditional Medicaid or from traditional Medicaid to an MCO. So we streamlined that process due to provider issues so that there only has to be one prior authorization, everybody will use that same prior authorization request. You don't have to have multiples. The other issue that we had, was, that we kind of had to put a policy in place, was when you have the MCO come back and recoup and then you bill the new MCO and it is denied because of timely. So it's still -- there's still issues there because of the system. We are working on that. We're trying to get that corrected, but as a workaround, you know, we go the appeals

route. After that, they are denied for timely. But we are aware of that issue in the amount of time that it takes. It takes time to be able to correct that in our systems and be able to fix, or create a fix, for that so that automatically picks up in the system. So it's not an easy fix, apparently, according to our systems folks, and we are working on a solution for that particular issue.

MS. SAGASER: Justin, did they give you an ETA on that? Like, is it --

MR. DEARINGER: No. No, I don't have any ETA, at all. It's Systems, so I don't know. I can tell you that we, you know, we try to get those paid as soon as possible when it comes to our attention. If it's something that we get a lot of provider feedback on our website, or on our email address, because of these and we tried to get them paid as soon as possible, and it's just kind of a -- it's not a fix all, but it's something we can offer for now that's helping providers to get paid quicker, until we are able to get

that fixed.

MR. LYNN: Sorry. I was muted. Hopefully that will happen soon.

MR. DEARINGER: Yeah. I mean, I hope so. Systems, for some reason, we struggle with, with time.

MS. SAGASER: Justin, who is over the systems? Like, if we wanted to try and set a meeting with them, like they hear it from you, but sometimes when they hear from providers, who would be the appropriate person for us to do that?

MR. DEARINGER: Well, they are our contractor, so we generally don't set meetings between our contractors and providers.

MS. SAGASER: So they are not with the state?

MR. DEARINGER: No.

MS. SAGASER: It's a contractor?

MR. DEARINGER: Correct.

MS. SAGASER: Does the state ever look at different contractors?

MR. DEARINGER: Sure. We do bids quite often, and when they're

contract runs up.

MS. SAGASER: Okay.

MR. DEARINGER: We are in the process right now of switching between two systems. I think that is the thing that everybody needs to kind of keep in mind. It's not a normal time. We are changing two completely different payment systems. So the old system is ending, sunsetting, and the new system is beginning and we are right in the middle of those two phases.

So right now, we are doing training sessions and transitions and so the new systems built and completed and the old system is sunsetting, so this is a completely new workable that we are trying to throw into the new system, so it's, you know, it goes against a lot of what was already written in the new system so we are trying to go back and rework it and refigure it, and at the same time we are trying to figure out how we can, maybe, stick it in the old system until we can transition, so it's not a simple fix.

MS. SAGASER: And that brings up

a question that might be new business, but would that affect anything on our end with that new system? Like, will we need to do anything differently for you guys?

MR. DEARINGER: No. I think everything will flow just like it always has for you all.

MS. SAGASER: Thank you.

MS. MARSHALL: So this is Pam again, and Renea you might be able to comment what you all are experiencing with the retro, but it is the volume, you know, it's a high volume and it's a lengthy amount of time to get the MCO to recoup. We are still required by fee-for-service Medicaid to get a prior auth, so we still have to go through that process. They are not honoring --

MR. DEARINGER: They should be now. If you have anything, anything --

MS. MARSHALL: They're not.

MR. DEARINGER: Okay. You've had something within the last couple of weeks?

MS. MARSHALL: Uh-huh. PAs are

still being required. That's what I'm being told.

MR. DEARINGER: Could you share with me who told you that?

MS. MARSHALL: Sure.

MR. DEARINGER: That's not the case. Somebody's just not informed. I appreciate it. I will do a better job of getting that information out to whoever possible, to whoever is misinformed.

MS. MARSHALL: Yeah. It's the -- you know, our rep, our Medicaid rep, Vicki Hicks, is having to process, manually process all of the claims and it is just time consuming, because they would all deny for timely, so the system doesn't allow an override in this situation, and it ends up being a manual process. It's taking -- it can take three to six months for us to get repaid.

MR. LYNN: Okay. I guess we can move on to the third item. And that's regarding the caregiver CPT codes for caregiver training. I know that Justin, you mentioned that you guys approved

those, but I didn't see them on the fee schedule. Is there a reason for that?

MR. DEARINGER: No. Those codes have been added to the fee schedule. They should be there -- if they're not there today, they should show quick within about a week or so. Sometimes our website isn't updated as quickly as -- it takes a few weeks. But those have been added.

MR. LYNN: Okay. Good. Sounds good.

MS. CAMPBELL: I was able to access those on the fee schedule earlier this week, or late last week.

MR. LYNN: Good.

MR. DEARINGER: Good.

MR. LYNN: Yeah, I haven't looked in a week so it's right around there.

MR. DEARINGER: Just kind of keep in mind with those things, that it takes a couple weeks for the website to catch up with the updates.

MS. MARSHALL: Mm-hmm.

MR. DEARINGER: It goes through

a process.

MS. MARSHALL: Dale? It's Pam again. Can I ask a question regarding those codes?

MR. LYNN: Sure.

MS. MARSHALL: So the key about these codes is it is without the Medicaid member present, so it is the caregiver and the therapist, for example, together. So if the child was seen on the same day, for example, and a different therapist saw the child for caregiver training, we are just wondering how can you put, you know, there are other disciplines that you can put two MPI's, two different providers on the same claim billing two different codes, and/or say a child had a session this week, and another day they saw, they were billed for caregiver training, does that use up an additional visit? Like, if they are on the same claim, that wouldn't use an additional visit, but if they are not on the same claim, does that use, in the prior auth period, does that use a visit? Or are these codes outside of the prior

auth?

MR. DEARINGER: That's a good question. I'll have to get back to you on that.

MR. LYNN: Okay, we can move to item 4, physician signature on Plan of Care. I sent this out before I received the March 7th provider letter that states the policy clarification related to the physician signatures on Plan of Care. I sent that out to all of the TAC members. I hope you got it. Would you like to review it or have discussion?

MS. SAGASER: Dale, it might have just been me, but it was a little contradicting. It was still a little muddy. I don't know if anybody else felt like that or if they felt like it was clear. Maybe it was just me reading it last night after a long meeting.

MS. MARSHALL: No. Renea, this is Pam. I agree with you.

MS. SAGASER: Okay.

MR. DEARINGER: I can help with any questions you might have.

MS. MARSHALL: Also Renea, I'm not sure if you have this question as well. Typically, I wondered if the Physician TAC had seen this. Typically kids go for annual checkups at the older ages, obviously, if we are treating a 4-year-old or 5-year-old, they are not being seen by a physician typically at the six-month mark. So the question I had is, could we not change this to an annual situation since their regular well checkup is more of an annual event. That way, if they are, you know, still being treated at that one-year mark, it might be more in line, because we tend to get referrals after they've been to their annual checkup. That's when the physician -- that's a typical time that they refer, so I was just wondering if anyone had that thought and if the rhythm of how that pediatrician is seeing that child, it seems to make more sense to do that.

MR. LYNN: That's a good point.

MS. SAGASER: Well, I mean, we still have -- I guess my question -- we

still have to get the Plan of Care for, just, other insurance companies and their timelines are different, as well, so, like, our processes still have to stay in place. I think, I'd have to pull it back up, but we still have to have a Plan of Care and certain ones still require -- certain commercial plans still require that in their time frame. I think where I was muddied, and I don't have it pulled up on the screen, correct me if I'm wrong, you can try to get a signature, but if you don't, it's okay, or something like that. I don't know if I was reading it like that, and so I was like, what does it matter then, if you try or you don't? Justin, was I reading that wrong? That's what I was confused about.

MR. DEARINGER: So there is no signature requirement, initially. There is a physician's order to get therapy services. You all, as providers, provide that Plan of Care. You work with the doctors as needed, which is, I think, what you are talking about and maybe what you

read. So the administrative regulation, it says that you cooperated with the physician's office. So you cooperate with them to complete and create your Plan of Care. If there's any substantial change in that Plan of Care, that would indicate a change from why the physician sent the individual in the first place, then that Plan of Care, that corrected Plan of Care would need to be signed by a physician or a physician's office, and you can see who all is allowed to sign that from a physician's office in a letter. And if the services last six months at that time, then there would need to be a signature as well.

So that is the two caveats. Remember, we are working on a few issues to, maybe, we are working on one issue that has a possibility in the future of having some diagnosis codes that are exempt from the 20 limit prior authorization. Those would be exempt from that six-month requirement, as well. But for right now, those are the two times

that a signature would need to be provided, and other than that, it's just cooperating with the, you know, we are in collaboration with the physician's office as needed. So I'm not trying to get a signature, just working with them, as needed, for you to complete your Plan of Care.

MS. SAGASER: Okay. Thank you for that clarification.

MS. MARSHALL: Justin, it's Pam again. I have a few questions around that. Are we going to define what a change is? I'm only asking this because if this gets put in place, it becomes a reimbursement issue. Becomes an issue that a payer could, if it's not clearly defined, they could recoup the money saying this Plan of Care changed and you didn't get a signature on it. They can, you know, just make up what the change is. The goals should change on a Plan of Care that shows progress or change, but I think what you are meaning is frequency or duration or something of that nature, but

I think the change has to be defined, or else any change on the Plan of Care could mean, you know, and we can't get a prior auth if we are not showing progress. That's part of medical necessity. So it all has to line up.

MR. DEARINGER: Yeah. We can look at, maybe, possibly, doing that. I think if we were to define significant change, we would probably add that to the administrative regulation and go through that process. I don't think we want to do that outside of the administrative regulation. It kind of boxes you in to your all's judgment. I think we see significant change, and that definitely doesn't mean that their goals are changing or progress is being made. You know, that's a change to why the physician sent them there in the first place. So we will look at adding that to the administration regulation, absolutely.

MS. WILSON: And just for clarification, this applies to all Medicaid plans, it's not just

fee-for-service or anything like that?

MR. DEARINGER: That's correct.

MS. MARSHALL: So does anyone else have concerns about reimbursement along the lines of this? Because if it's not clearly defined, then that allows -- and this is happening in audits. We have had payers say: You don't have a Plan of Care signed for this claim. And, you know, I can just see this going that way in audits, wanting to recoup based on their interpretation of a change, a significant change, or anything else if anyone has any other thoughts.

MR. LYNN: I think, Pam, this first paragraph, last sentence states a signature from the physician or physician's office will no longer be required on the Plan of Care. That's pretty -- I don't think you can piece out well, for reimbursement purposes it does, that statement is pretty clear, I think.

MS. WILSON: I think what she is talking about, Dale, is that second paragraph there. The significant Plan of

Care modification, that that's when you do have to have a signature. Our concern is that, what is the definition of "significant," because we do need some better wording, there, because that's very subjective as to what I think is significant, and the person over here thinks is significant, or whatever. Pam's right, I think that they're going to come back and say -- they can say whatever they want to say, really, if the language is not very clear. If it's supposed to be -- and I think I understand, I think, Justin, what you're trying to say. Let's say that the child is being referred for torticollis, but then later on they are toe walking. That is a different thing. Yeah, it is still PT, but it's how that's being treated and the goals and all of that are changing. But that's not clear from the word, "significant," I don't think.

MS. MARSHALL: And also --

MS. WILSON: Go ahead, Pam.

MS. MARSHALL: The timeline of

that significant change. So for example, there is a regular rhythm of treating that child and does that signature need to happen within 30 days of that change of that Plan of Care? Within 14 days? What is that timeline on either side? In my opinion, it's very hard to get that Plan of Care sent back in any less than 30 days. So that's another concern to be able to meet the requirement of that significant change and what constitutes an episode of care?

So, like, Kresta said, if we use the example of a torticollis baby. Came in for torticollis, was treated, and then a new thing develops, if they ended care for 30 days, is that, then, a new episode of care, or does it have to be more than three months, or, you know, those are the questions that I have.

MR. DEARINGER: Yeah, I think those are good questions, Pam, and I think those are the things that we are trying to put into the administrative regulation and so those will be things that will be added

there. I don't know if we want to completely define that in policy. If there is any issue, though, with payment, as far as being extremely subjective or picky as far as goals changing or something like that, please feel free to reach out and let us know so we can mediate that through the process. And we are working on that administrative regulation at this time so we have to kind of follow the normal rhythm of promulgating and administrative regulation so that will take a little bit of time.

MR. LYNN: Are you ready to move on to item 5? A request to add a speech therapy fee schedule, CPT code, 92605 evaluation for prescription of non-speech generating augmentative and alternative communication device, face-to-face with the patient, first hour.

Justin, you said that you would have that added to the fee schedule and maybe it's just a matter of time, just like the other ones, just hasn't got on there yet?

MR. DEARINGER: This one is a little different. So we are still, kind of, in the process of reviewing this one. This code is not covered by a lot of the surrounding states. It's not covered by a lot of states period, so this one is going to take a little bit longer to research. We are having to really dig to even find a state that covers it, or a grouping of states, so this one is going to take a little bit more time to decide whether we can add it or not. But it still in the research phase, and as soon as we get something definitive, I will let you know.

MR. LYNN: Okay, thank you.

MS. WILSON: The things I read on that recently, Dale, were that 92507 ios basically supposed to encompass that code since its non-speech generating, so I think if I had to guess, the code will probably, kind of, go away, eventually. I don't know how soon or how frequently people are wanting to use it, but for that case, 92507, is pretty much what we are stuck with.

MR. LYNN: All right.

The last item, here, is provider reports when requesting ST PA through the DMS portal. They are asking for proof that the patient is not receiving duplicate services at school. I think it was, maybe, resolved at the last meeting that they cannot ask you for that. Is there any discussion on that?

MR. DEARINGER: That should have been corrected. That shouldn't be an issue anymore. If it is, please reach out and we'll take care of any specific instances, but that should not be an issue again. We were told that was, again, a training issue and that shouldn't happen anymore. I think we have taken care of that.

MR. LYNN: All right. Sounds good. Thank you.

MS. SAGASER: I apologize, my computer was not working right this morning. On the first one, so I missed that. Can you let me know what was the follow-up?

MR. LYNN: For number six?

MS. SAGASER: No. For number one.

MR. LYNN: Number one?

MR. DEARINGER: Still in process of that review. It has not been completed.

MS. SAGASER: In January, there was a meeting that was supposed to happen with the Senate from the Secretary and the Commissioner's office and they, based on -- they said they would have some data sent to them, and they have not received, that is my understanding. Do you have any confirmation on when that is going to get to them, because we are in the last few weeks, here, of the budget. Like, it's coming down to a crunch and they are still waiting, and they said in January they would have it to them.

MR. DEARINGER: I know there has been quite a bit of information related to the legislature based on rates.

MS. SAGASER: It's my understanding that they have not received,

in the meeting that we had at the state level, that they have not received that information that they specifically asked for, based on speech OT and PT. Not talking about the other information that the state's been giving them, but they are requesting, specifically, some points from ST OT and PT.

MR. DEARINGER: If you can email me what specific legislators you are referring to, I can go back and look and we can --

MS. SAGASER: It -- Veronica has that information and she was -- and Secretary Friedlander. I mean, they had said that they were going to get that information back, so.

MR. DEARINGER: I'll get that information and get back with some specifics for you.

MS. SAGASER: Yeah, it's just the data for the amount for pediatric and outpatient, and then also regular, like, all of the amounts with their codes --

MR. DEARINGER: Sure.

MS. SAGASER: -- to see the impact of the budget, and I think that is what they are waiting on.

MR. DEARINGER: I will let you know. We have all that research. We sent that out to multiple parties so I'll see and get back exactly who and when and all that good stuff.

MS. MARSHALL: And Justin, it's Pam. Do you have any update on the 900 million-dollar Medicaid shortfall that the Senate is dealing with in the budget? Because that would actually mean cuts for everybody across the board.

MR. DEARINGER: No. No update right now.

MR. LYNN: So any other new business?

Do we have any recommendations to the MAC from this meeting?

If not, the next TAC meeting is Tuesday, May 14th. And we will see everyone then.

Meeting adjourned.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 13th of March, 2024

/s/ Stefanie Sweet

Stefanie Sweet, CVR, RCP-M