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

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Via Videoconference
November 1, 2022
Commencing at 8:31 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dale Lynn, Chair

Linda Derossett

Kresta Wilson

Emily Sacca

Renea Sagaser (Not present)

MR. LYNN: All right. Good morning, everyone. It looks like we have a quorum, and the first thing on the agenda is -- I have the wrong date on the agenda. I apologize for that. I have November 1st, 2002, but it's 2022. But the first thing on the agenda is to review and approve the July minutes.

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

MR. LYNN: Okay. Thank you.

MS. WILSON: I'll second that, Dale.

MR. LYNN: It looks we have six items on the old business. The first item is the follow-up from the Department of Medicaid Services. Has the CPT 92606 nonspeech generating ACC (sic) been added to the speech fee schedule yet? We had talked about that at the July meeting, but it wasn't clear whether that was ever added.

Anybody from DMS able to fill us in on that?

MS. BICKERS: I'm scrolling through to see if we have anybody from policy on the

line yet.

MR. LYNN: Okay.

MS. BICKERS: It looks like I have a few people trying to connect, but I do not see anyone from policy at this very second.

MR. LYNN: Well, we can maybe circle back on that one, then.

The next item is a follow-up from WellCare. I think I seen Jason on here.

MR. MINGUS: Yes, Dale. How are you doing?

MR. LYNN: Doing great, Jason. How are you?

MR. MINGUS: Pretty good.

MR. LYNN: Currently, WellCare doesn't allow speech evaluations and treatment on the same day, and it was requested that that be changed to the same policy for OT and PT. And at the last meeting, that was discussed.

And I understand there was going to be a meeting -- WellCare was going to have a meeting on Friday, July 15, to discuss that issue.

MR. MINGUS: Yeah. I've -- I was

on vacation the last time you all got together, so someone stood in for me. I think Stuart Owen did. He was one of our operations managers.

And so we've been internally -- and I'm going to send over some information to you, I guess, to whoever I need to email it to. We pulled several hundred claims, and there are six different denial reasons that we were able to obtain. But none of them specifically point to ST eval/therapy not allowed on same day.

So I think last meeting, Stuart, or whoever stood in for me, asked for examples, claim examples, and we really need to see those at this point. Because we, with the data we pulled, do not see specifically where the eval/therapy on same day is being denied. We can't find that reason. We got some of the other reasons for denials but not that one.

So I would really -- I really need to see some examples, if I could. Two or three should do it. And then I'll take that back to our operations team, and we can take a

further look at this issue.

MR. LYNN: Okay.

MS. SACCA: Dale, this is Emily. Was it more just a clarification and a policy update that had occurred versus an actual denied claim?

MR. LYNN: Say that again. I'm sorry, Emily.

MS. SACCA: Was it actually just a policy clarification, that someone had been given that information that it was a written policy, not actually having a denied claim? I feel like that was the conversation last meeting, was there was --

MR. LYNN: That might have been what it was.

MR. MINGUS: So I can go back and make sure about the -- if it's a policy question, I can definitely follow up today on that and get you guys a response.

MS. SACCA: That would be great. Thank you.

MR. MINGUS: Now, I do want you to have this information, though, about the denials just so you know what we are seeing

and then I'm glad to go back and find out about the policy. I should probably be able to get you an answer back on that, I would think, this week.

MR. LYNN: Sounds good, Jason.

MR. MINGUS: Okay. Who do I need to email the information about the denials to? Is that to you, Dale, or to --

MR. LYNN: Yeah. That would be me.

MR. MINGUS: Would you please give me your email, sir?

MR. LYNN: Sure. I can put it in the --

MR. MINGUS: Chat. That's fine.

MR. LYNN: -- chat.

MR. MINGUS: Thank you so much.

MS. BICKERS: Also, Jason, if you'd like to email that to me, I can make sure it gets out to the group as a whole.

MR. MINGUS: Okay. And would you put your email in the chat, too, please?

MS. BICKERS: Absolutely.

MR. MINGUS: Thank you much, ma'am.

MR. LYNN: All right. The next old business is a follow-up regarding

UnitedHealthcare's policy that peer-to-peer be with a referring MD rather than a providing therapist. Are there any updates on revising that policy?

MR. KERN: Good morning. This is Chris Kern with UnitedHealthcare. Can everybody hear me okay?

MR. LYNN: Sure can.

MR. KERN: Can you unmute Dr. Divya Cantor? She's going to respond to that particular item. Dr. Cantor?

(No response.)

MR. KERN: Okay. She may not be able to speak, so I'll go ahead and address it.

MS. BICKERS: I don't see her logged in, Chris. I'm sorry.

MR. KERN: Okay.

MR. LYNN: I don't see her either.

MR. KERN: Okay. She was IM'ing me and thought she was in, but perhaps there's something that went wrong. I apologize. Oh, nope. She just said she's here. Hold on a second. Okay. She says she's still muted.

MS. BICKERS: Is she logged in

under a phone number? Because I don't see her name on the screen as usual. My apologies.

MR. KERN: Yeah. No, no. That's okay. I was thinking the same thing. Perhaps she was under a phone number.

MR. LYNN: Yeah. I don't see her either.

MR. KERN: I'm asking her right now.

MS. BICKERS: Because she should be able to unmute herself.

MR. KERN: Okay. Okay. She says she is unmuted on her end. She says she's got --

MS. PARKER: I would suggest she go back out and come back in.

MR. KERN: Okay.

MS. PARKER: Because she's not -- obviously, we're not seeing her, so maybe she should try that.

This is Angie Parker with Medicaid. I just wanted everybody to see in the chat that I looked up the 92606, and it was added to the fee schedule on August 3, 2022, with an

effective date of 1/1/22.

MR. LYNN: All right. Thank you, Angie. Appreciate that.

MS. PARKER: You're welcome.

MR. KERN: She may be at the phone number ending in 8394. Well, no. She says she's going to dial back in. Can we go ahead and come back to No. 3 or 4? And if she's not able to get in, I can address these issues. I just think she really would like to take those two items.

MR. LYNN: Sure. That would be fine. The Item 5 was that -- claim code issues. NCCI edits are released quarterly. Any update on a timeline from DMS or the MCOs on a timeline of uploading NCCI edits? I think it was unclear at the last meeting that -- how long it took to update that. Was it up to three months or something like that?

MS. PARKER: This is Angie with Medicaid. I can't answer that. Can any of the MCOs answer that?

MR. MINGUS: This is Jay with WellCare. Again, I'm not sure on that, but I'm glad to take that back as a takeaway,

though. And I'll try to find out what I can and reply back.

MR. KERN: And this is Chris with UnitedHealthcare. Is there a specific NCCI edit that you guys are looking for an update on? I know there's more than one. If there's a specific one you're looking to target, I can certainly provide an update for you regarding that.

MS. MARSHALL: Hey, Dale. This is Pam Marshall. Can you hear me?

MR. LYNN: Yeah. Go ahead, Pam.

MS. MARSHALL: So we want some clarification -- this is something I've been working on. There is a CMS NCCI edit and then there's a Medicaid NCCI edit. And so we wanted clarification on which NCCI edit that Medicaid is using; therefore, which chart is -- because there are differences between the two. And there are a couple of code sets that are off the CMS ones that are on the Medicaid ones. So can anyone speak to that? Which one is being followed?

(No response.)

MR. LYNN: I don't suppose there's

anybody that can.

MS. MARSHALL: Okay. Well, I suppose, Dale, we need to submit a question, then, so it gets answered. Which NCCI chart is being followed? Because what is happening currently -- and I think this is across the state, from my understanding -- is several of the MCOs have hired Cotiviti, which is a third-party manager of the claim edits. And the claims are on any code set.

You know, originally, the history of a 59 modifier was not intended to be applied to therapy. In my opinion, I think it was for upcoding and, you know, lots of other provider types but not in -- especially not in Medicaid because it is one-to- -- you know, with children, it's a one-to-one relationship, meaning it's one child to one therapist. Therefore, a 59 modifier is looked at as a bundling -- like a bundling procedure.

However, we don't treat more than one code in a 15-minute period. That's against CMS regulation. So there should be no bundling edit applied to what we're doing.

We only have a small code set and, you know, we only bill a very small number of codes. And there's only one code being billed every 15 minutes.

So if there's an NCCI edit pair -- for example, say you do two units of one code and two units of another code in the same hour session for that child, Cotiviti will only pay the Column 1 code. And the Column 2 code that has the 59 on it will go unpaid.

And there typically is not even a reason code that requires medical records. But when you call to follow up on the claim, it's requiring medical records for providers to send in. It's a huge administrative burden.

And in my opinion, you know, these codes should not be NCCI edit pairs, and it was successfully removed -- some of these pairs were successfully removed from BCMS. Both EPTA and AOTA, which are the national organizations for PT and OT, in the last two years, have done a lot of work to get legislators and people on the CMS level federally to understand that.

So it's an important issue for our

state, that we need to understand what NCCI chart is being loaded for Medicaid. And can we look at that as a state, whether we want some of those pairs -- you know, want to challenge some of those NCCI edit pairs?

MR. KERN: This is Chris Kern with United again. You may not know whether or not any of United's claims are involved in that. I just jotted down some more specifics, and I can take that back. That helps me kind of hone in on what you're specifically looking for.

However, if there are some claim denials involving United, if you could please maybe put your email address in the chat. I'd be happy to work with you offline to address that. But I can see if I can get an update on this particular item, modifier 59, in the NCCI edit charts load for United. Thank you for the clarification.

MS. HARRISON: Hi. This is Samantha Harrison also with Humana Healthy Horizons. So we would be happy to do that research as well, and if you can identify if we were one of the MCOs where you're

receiving denials or a request for provider medical records, we'd be happy to dig into that further in regards to NCCI edits.

We review -- we do utilize Cotiviti, and we also utilize, I believe, both the CMS and state NCCI edits. And if the state NCCI edit -- if there isn't one, then we would fall to the CMS. So we'll get further clarity to provide exactly what our process is and be able to share that back.

MS. MARSHALL: Okay. This is Pam Marshall. At least I can speak for our practice, but others may have to speak up for their own practices. I know that Humana MCO is one because you all use Cotiviti.

And just for clarification, the payment that comes back is nonpayment on the Column 2 code, and there is no reason code that requires medical records. It just -- it typically has that bundling, you know, reason code on it. And then when you call, in further research, they say, well, we need medical records.

It's just kind of -- you know, it just feels like one of those games that you -- and

it is a huge administrative burden when you have -- you know, there's certain practices around the state, I'm sure, that have hundreds of claims. And because more MCOs are utilizing Cotiviti, it's a tactic that Cotiviti uses.

MS. HARRISON: So I will add our email address to send a couple of claims examples, if you don't mind, to the chat. And we'll be happy to do research and dig into that for you, for Humana Healthy Horizons.

MS. MARSHALL: Okay. And can you repeat your name one more time?

MS. HARRISON: I'm Samantha Harrison.

MS. MARSHALL: Okay. Thank you, Samantha.

MR. LYNN: Thank you, Samantha.

MS. OWENS: Hey, and this is Holly with Anthem. I'm happy to take that back as well and get some more information for you.

MR. MINGUS: And Jay with WellCare. I'm happy to do that as well.

MS. ROPER: And good morning. This

is Crystal with Passport. I have made notes as well. I will take that back for further review.

I did ask our operations team the last time, too, in regards to, kind of, our process in regards to updating the NCCI edits. They said that we don't necessarily have a time frame that we update them, but we do update them accordingly when they are released quarterly and make sure that our systems are aligned. But I will make sure to confirm kind of which -- which NCCI edit chart they are updating, too.

MS. MARSHALL: Yes. That would be helpful. And I believe, if you all can confirm, it's Anthem, WellCare, and Humana that's using Cotiviti. Passport, are you using Cotiviti?

MS. ROPER: Not to my knowledge, no, ma'am.

MS. MARSHALL: Yeah. I don't think so either. Okay.

MR. LYNN: Thank you for all your help with that. So we want to follow back to No. 3 and 4.

MR. KERN: Yes. Thank you, Dale. I believe Dr. Cantor can speak now, so I'll turn the floor over to her.

MR. LYNN: Okay. Thank you.

DR. CANTOR: Yes. Good morning. Thank you. This is Dr. Cantor with WellCare.

So there were two questions. One is regarding an update on a possible change to a peer-to-peer being done with the referring therapist versus the referring doctor. And, currently, there is not a plan for a change in -- from UnitedHealthcare's perspective.

And I think that I would ask for -- if there were problems that you're having with our medical directors or if there's a more particular issue, I would be welcome -- I would welcome hearing about that in more detail and understanding that. But at this time, there is no change for that particular policy.

The other -- or I can move on unless there's a question on that.

MR. LYNN: Well, yeah. It's just awful difficult for a peer-to-peer with a physician. The physicians don't really have

time for it and, often, they really prefer that it be a providing therapist to do a peer-to-peer because they know more about therapy than the physician does and what the therapist is actually requesting.

And that's the reason for that. It's just the physicians don't have time for it and don't understand the -- exactly what the therapist is doing as well as a therapist does.

DR. CANTOR: Sure. I can understand that. That's -- having been doing this for as long as I have, I'd like to understand where -- I'd like to know how we can improve that within the confines that we have within our own company in that sense.

And the hope would be that the PCP specifically is understanding the overall case for the member, but I just -- I was asking our medical directors, who do these reviews, what their thoughts were in terms of: Was it constraining? Did they feel like they weren't able to get the information? And I wasn't getting a lot of negative feedback from them.

So I think that, again, I'd love to know if there's an example that I can use to be able to go back to my company. That would -- that would be helpful, are live examples on that.

MR. LYNN: We'll try to provide more of an example of a difficulty there.

DR. CANTOR: Thank you. Thank you. Number 2, if we can move on, if you're okay, has actually two parts. It's a follow-up on a policy requiring office visit prior to referral therapy and then start and stop time questions for the CPT codes.

So the first part, the office -- UHC policy requiring office visits prior to therapy referral, that's an inaccurate statement. Since last summer, the initial outpatient PT/OT/ST visit one for each of those therapies can be administratively approved along with an eval in order to avoid any delay in care.

The prior auth request can then be approved when med nec -- when medically necessary for any -- for up to ten more visits. And an order, whether it's verbal or

signed, and the plan of care unsigned is required when requests are needed beyond the ten visits.

And the reason that we're saying an order that's signed is because it's based on the KAR, 907 KAR 8:020. And so that's -- so it's incorrect. We do not need an office visit prior to a therapy referral. There are basically up to ten visits that you can get without a referral. If you need more than ten referrals (sic), then we're requesting a signed verbal or a written signed plan of care.

We do allow 20 therapy visits per member per year. And if more are needed, then they can be reviewed for medical necessity. Any questions on that?

MR. LYNN: Yeah. I guess that was more of a clarification question from the last meeting. So they don't need a physician's office visit prior to --

DR. CANTOR: Correct.

MR. LYNN: Okay. That's good to know.

DR. CANTOR: Good. Good. Then the

other part of No. 2 was UHC -- I'm sorry. Was there a question?

MS. MARSHALL: Yes. I had a question, and it's Pam Marshall. So, you know, this was an issue that when UnitedHealthcare was coming into the state, we had discussed and I personally had discussed with the contracting manager, is you will likely find people going out of network with United if you're continuing to require the signed plan of care.

And here's why that is such -- it's so problematic, and perhaps you can survey and go to the Physician TAC and talk to -- discuss it with them, is it truly is a challenge to get them to sign that plan of care. We're already, you know, getting orders, and there's timelines in the orders and those type of things.

But the way that works is, you know, scheduling for that -- that child has to be put on hold until that comes back. And there are some times where there's larger hospital systems, and it just may take 30 days to get that signature back.

So when you've got an infant that has urgent needs, like a feeding problem or, you know, an infant that has torticollis, that you want to see that infant make progress in six visits rather than later in life when they're going to maybe have six months of therapy.

Those things are under the gun for time, and just following that is a burden even on us to administratively track it down. Sometimes we have to physically send a person to that office to get that thing completed.

So that's where the challenge is, is it's not that no one wants to comply. It's just it's a really unrealistic, you know, difficult thing in the world of therapy, to get that signature on that plan of care.

DR. CANTOR: So I'll just refresh that again, that ten visits are available without a referral. And the signed or a verbal signature will suffice after the ten visits, and -- and we're basing it on the KAR.

MS. MARSHALL: Okay. So how is a verbal signature given? Just I don't -- I

don't know anything about that, so if you could explain that.

DR. CANTOR: Well, a verbal order. It's like a verbal order. Just if you were -- if you were in the hospital setting and you were calling in to the nurse's station asking for a service or something to be done, it can be done verbally versus physically having to be there. So that's acceptable, that verbal order received from Dr. Jones.

MS. MARSHALL: Great.

DR. CANTOR: I hope that helps, but we certainly will take that back as well. I think, from our perspective, the fact that it's in the KAR is our biggest stumbling block.

MR. LYNN: I'd like to go back to follow up on the peer-to-peer. Miranda Garvin is also on the call with us, and I think she has some more specific examples of what would be, you know, a difficult situation with having a peer-to-peer with a physician.

Do you care to speak about that,

Miranda?

MS. GARVIN: Yeah. Absolutely. Can you hear me okay?

MR. LYNN: Yes.

MS. GARVIN: Yeah. So setting up the peer-to-peer between either the referring physician or a primary care physician is next to impossible when we are trying to coordinate who's going to call them, when they're going to call them. Are the physicians going to be able to get in touch with one another? Is the physician up to date with all of the patient's most recent therapy information?

So we can send those documents but, I mean, we don't know whether or not they have had time to read them and are fully equipped for that one-time phone call that can really make it or break it for the patients that we serve.

Whereas, the therapist, they might be seeing that patient three times a week, are very intimately involved in the therapy details. They know what is needed.

And just the scheduling of all of that

is really a challenge of our therapy team then trying to call the physician's office, talking to either the secretary or the medical assistant, coordinating when the physician is available, crossing our fingers that the physician is available at the same time that the payor physician is available, and that the physician has read the notes and is equipped to have that challenging discussion that -- at least for the patients that we are serving on Frazier's downtown campus, they have a spinal cord injury, a stroke, a brain injury. Additional visits are critical for this person's recovery.

DR. CANTOR: Miranda, I'm sorry. I didn't catch your last name.

MS. GARVIN: Sure. It's Garvin.

DR. CANTOR: And you are with Frazier?

MS. GARVIN: Yes, ma'am.

DR. CANTOR: Thank you. Is -- when I look at our denial rates for therapies, it's really low. So I'm curious how frequently you're experiencing this, and I would welcome, if you've got a particular

member -- because our denial rates for therapies are low, so I'm just wondering -- I just scratch my head about this.

Because I didn't hear a lot from our medical directors that there was a connection problem. Because having done my share of peer-to-peer calls, I understand everything that you just said. It's really hard. It's hard enough to get ahold of our own family members, let alone two busy people.

MS. GARVIN: Right. Right. Well, I have a couple of things to share, just from the new business side of things from this meeting today. But we at Frazier, when authorizations -- and this is not just for UnitedHealthcare but across the board with Kentucky Medicaid and any managed Medicaid plans, we saw a significant uptick in denials really throughout June and July. We had a drop in 15 percent of Medicaid between May and June.

And so that was concerning to us, and the clinics that I manage at Frazier are those complex medical, neurologic conditions so...

DR. CANTOR: Yeah. No. Absolutely.

MS. GARVIN: I have nine particular cases that, you know, I don't have listed on here specific which plan they had, but these are all Medicaid or managed Medicaid. And diagnoses of tetraplegia, stroke, brain injury, Down syndrome, I mean, complicated cases.

DR. CANTOR: Sure. We have a therapist on our staff.

MS. GARVIN: Sure.

DR. CANTOR: And so I, again, just wonder, only with my UHC hat on, what's happening here. Would it be helpful to have just a separate call with you?

MS. GARVIN: Absolutely. I think that would be very, very helpful.

DR. CANTOR: Would that be okay? All right. Chris, could you help get that scheduled for me, please?

MR. KERN: You took the words right out of my mouth, Dr. Cantor.

Miranda, my email address is in the chat.

MS. GARVIN: Okay.

MR. KERN: And if you will send me your contact information, Dr. Cantor, I'd be very happy to get that set up with us, for us.

DR. CANTOR: Thanks.

MS. GARVIN: Awesome. I appreciate that. Thank you.

DR. CANTOR: Absolutely. No. It's -- truly, our goal is not to hinder and to create barriers. It really, really is not. I know it may sound fluffy, but it's just not -- that's not how we are here. So we'll work on it offline, Miranda.

MS. MARSHALL: Can you all also provide the KAR number that you were referring to?

DR. CANTOR: Yes. 907 KAR 8:020.

MS. MARSHALL: Thank you.

DR. CANTOR: And then the last -- the second point was around the start/stop times. And just as a refresher, the hierarchy of review for utilization management, the first one is eligibility. The member has to be eligible for -- as a

member of our MCO. We then follow federal and state laws. Then we use InterQual. And then the last would be our UHC medical guidelines.

And so I know that we've spoken about InterQual at this -- at this venue before. Those are proprietary. They require a license for the therapist to be able to physically review. I am unable to share them publicly like that because of the licensure.

But the reason that we have the start and stop times in our medical guideline is, again, because of a KAR. And that one is 907 KAR 040. And it is under Section 3, bullet 2.C.3.

And I would ask: Is that causing a claim denial? Is it causing a -- I get the administrative part of it, but we're not using UH -- our own guideline. The reason we have it is because of the KAR. We use InterQual. And so I don't believe it's in InterQual.

But then I would like to go back and ask: Is it causing a problem with payment in any sort? I get the administrative part, but

to my knowledge, we're not using it for adjudication. So I'm curious what problems it might be causing other than it's in there.

MR. LYNN: Okay. That's a good clarification on that as well. Any other questions regarding that? If not, we can move over to new business.

And there is -- it's brought to my attention that there are a lot of providers dropping out of the First Steps due to the extensive trainings being required and the increased workload caused by this training requirement. And I haven't really worked in the First Steps program in quite some time, but maybe Kresta Wilson can give us some insight on that.

MS. WILSON: Well, this is not a new problem. This has been -- this was going on before COVID hit but certainly felt that more so when more providers dropped out during COVID which, I think, was partly because it was only telehealth, and they didn't do telehealth only.

And now that, you know, everything has opened back up, it's built back up a little

bit. But they're having a really difficult time finding providers, getting the kids seen.

So I don't know -- the training that they're requiring is so time-consuming. It takes something like, I don't know, seven months or something to complete. It's about the equivalent of a college course. They're not paid for that time. They have to do it on their own time.

They have to pay for, like, a book, purchase a book for the class. I'm not sure of the other -- any other expenses. But, obviously, time is, you know, very important. And it doesn't matter if they have, you know, one child they see or fifty. They have to do the training.

And so what we saw initially was lots of, you know, part-time providers dropped out. And I just think that there -- it doesn't seem like providers are valued, to be honest. I mean, that's really just the bottom line.

The best we got out of it was that some of the associations were able to get approval

for CEUs for those therapists for that course. But outside of that, it's super, super time-consuming, and it's something that I feel like could be very, very abbreviated and wouldn't cause such a burden on the providers. It's important information. It's about coaching families and that kind of thing, which is really important in early intervention.

But I just think that -- that's kind of the tip of the iceberg, I guess, but it's created as a snowball effect, you know, just more and more providers dropping out and meaning kids not getting served.

And I think the program as a whole is just suffering, and we're not able to get to those kids that need it desperately. You know, birth to three, such a crucial time in their home. Some of those kids are rural areas. They don't have access to a clinic of any sort. Or, you know, maybe it's semiclose, but they don't have transportation. I mean, there's, you know, all kinds of issues.

So I think there's definitely -- I don't

know if there's -- what we can do on our end, and I know we're working with our association somewhat. But it is -- it's a big problem, and I just feel like the program in general is not valued by those that are kind of heading it up as a whole. So that's -- that's about what I got so...

MR. LYNN: Yeah. I understand there's -- you know, there's a lot of hours being spent in this training and, I guess, filming in the home and everything of that nature to show that they're actually doing this type of training with the family.

MS. WILSON: Yeah. It's very time-consuming, and I think there are some issues with, like, getting videos in daycares and that kind of -- as you can imagine, that gets a little complicated when you have other children present. So I think there's a lot of logistical things, too, that become a problem.

But overall, you know, I think this -- I've been with First Steps since 2005, and it's such an important program. And if we don't service our kids birth to three, this

is -- you know, we're going to have much bigger problems down the road. And I know that it's optional for our state to have this program, but I just think everybody -- you know, as much as we can, as professionals, try to support and push that so that it doesn't go away.

I mean, you know, I think that there's always that concern. I don't know what it -- what that would look like but, you know, there are some states that don't have an early intervention program.

So I just think that, you know, as much as we can do professionally within our organizations and that -- you know, that's something that we can -- and at the state level, things that we can, you know, have our voice heard so...

MS. MARSHALL: Yeah. Kresta, this is Pam. I'm going to chime in with you. I, too, have been a First Steps provider since, gosh -- I think it's about 2005 as well. So the early intervention is very important, and I know there's a shift because the funds that support that program are both federally and

state. And it costs, you know, money to run that program.

However, the model is an educational model. It's not a medical model. And understanding that, we agree as -- you know, as providers with those changes. However, what we're saying is the burden is the amount of training it's taking to do this coaching model without compensation.

And the compensation is also an issue because the rate has not changed since 2005. If you look at the rate of inflation, the cost of gas, the cost of -- you know, everything it takes to drive and put that service on, I think we're about the only profession that we've gone backwards now in pay.

And the rate has stayed the same for -- you know, that is almost 20 years now. I think it was that rate prior to 2005. I just can't say the exact time. So it's been probably more than twenty years that the rate of pay has stayed exactly the same.

DR. THERIOT: Have they seen a difference? Has the State -- hi. This is

Dr. Theriot. Has the State-led agencies seen, I don't know, an improvement since they've been using the coaching model or -- I mean --

MS. MARSHALL: I don't -- I don't know who's measuring that. Do you, Kresta? That's a good question. Who's measuring that data? They're collecting it but...

MS. WILSON: Yeah. I think that would be the UofL team, the coaching team over at UofL. I would think they would have that data.

Now, I think you -- how do you define success? I think that maybe you're getting -- I guess you could argue you're getting more quality providers, quote, unquote. But, you know, you have so fewer but, you know, that's a tough argument, too. Because it's hard -- you know, I can't really say that, you know -- the providers that I've lost were some wonderful providers. And, you know, maybe they weren't trained specifically in this coaching training, but they were great therapists. So, I mean, it's hard to -- how do you define, you know,

successful, unsuccessful, whatever.

DR. THERIOT: Well, I'm wondering why they're -- I mean, they are pushing it so much.

MS. WILSON: Yeah. So I used to be on the ICC committee for several years with First Steps. And it had to do with meeting the federal OSEP regulations, and this was a push from Paula Goff and other entities at the State that said that in order to, you know, keep up with the Joneses, basically, that Kentucky had to do something. We had to do away with our toy bags and, you know, we had to push this coaching model.

And so I sat in those meetings for, like I said, four-plus years. And it was like, we would talk about these -- and we were all in agreement that yes, we need to do coaching, and we need to do these things. But the logistics of how that was going to roll out were never presented to us.

And then it was like, all of a sudden, one day, bam, here's what the program is going to look like, and we were just, like, flabbergasted. Because we're like, what do

you mean it's going to take -- you know, in the beginning, it took a year. I mean, hundreds of hours of training. And we just -- we're, like, how in the world.

So I think, you know, maybe on paper, that seemed good to them, but it was like the realities of that are not great.

So that was the push, was a federal thing. And there was definitely also a push to be one of the leading states in early intervention. And while that's a great goal, I guess my question is: At what cost?

So I'm worried that we're kind of, you know, shooting ourselves in the foot a little bit, you know, in trying to get ahead, I guess, or whatever that is perceived so...

MS. MARSHALL: And there's no reimbursement for that training. Just repeating that again, no reimbursement. It's an expectation that the therapists who have master's and doctorate degrees just give their time to that and then they have to prove fidelity with video recordings in intervals after that. And that, too, is not reimbursable; that is, donate your time to

this training.

And it doesn't count toward -- well, I think some of it now, Kresta, you said, does count toward licensure.

MS. WILSON: Some. It depends on what each state association has approved. So, you know, PT approved something. OT approved something. Speech approved something. But it's not the full amount that you're spending.

MS. MARSHALL: Right.

MS. WILSON: It's like -- I want to say the most is, like, 12 to 15 hours, but you're spending hundreds of hours, you know.

So yeah, it's real disheartening to the therapists, and I think a lot of them feel like they're -- I don't know what the right -- kind of like talked down to. Like, they don't really -- they don't know anything, you know. That's kind of -- this is just reports I'm getting from therapists.

MS. MARSHALL: Yeah.

MS. WILSON: And it's been from more than one.

MS. MARSHALL: And, Kresta, the

other concern I've always had is when you think about rural Kentucky, you think about eastern Kentucky. There isn't -- there aren't many therapists. And many times in the past, therapists would work for public school systems, and they would pick up maybe, you know, five to ten patients on the side and do them after school hours.

But now those therapists don't want to do this because they can't complete this training. So what's happening -- you know, the whole point of that early intervention is to get services in those areas that are limited and have -- don't have access.

And I feel like, you know, we see in our practice here in the Lexington, Richmond, Georgetown area children sometimes have had zero exposure to therapy. And these can be children who have significant developmental disability. If they have autism, a more severe form of it, they're not getting those services.

So I would be interested in the TAC requesting the data for the last several years to show what has happened. They must

be measuring it, three to five, in public schools as well. What's happening? How are children coming into the school system?

I know the pandemic is probably wrapped up in that as well, but I'm concerned as a whole for children that we're going to have this gap and this missing piece occurring, you know, this intervention occurring.

MS. WILSON: Yes.

MR. LYNN: Is that something that we should have a meeting maybe with Paula Goff?

MS. WILSON: Well, I think it needs to go higher than her personally. You know, and again, this is just one issue. There are many issues.

Payment is a big problem right now as well. You know, they're taking their sweet time with payments and, you know, up to the very last day and sometimes past due. And I know they're severely short-staffed, and they have been for, like, three years. I don't know what the hiring problem is up there, but it's like -- you know, that's a long time to be short-staffed.

And so it's just the lack of communication. You know, there's just a lot of -- there's a lot of things that I feel like we can do better, but it's difficult to get a person. You know, it's difficult to talk to somebody.

So I would love to be able to have some success there and kind of at least find out what's going on. You know, like, hey, what's happening here at the state level. You know, we'd love to know. But there's definitely not that reciprocal communication between the providers and the SLA staff. That's absolutely not happening on very minimal levels.

So it's -- and they lose staff and then it's not -- and they're not replaced. And so it's just more waiting, more waiting, more waiting so...

MS. MARSHALL: I think the data would tell us a lot. It would also be interesting to see the number of providers comparatively over the last five years, what's happened there. As they've implemented this program how they've gone

from, you know, X number down to whatever it is now. And then, you know, just the data on the children. Because they do measure at intervals their developmental progress, and that's all recorded, loaded in. The therapists load that in, some of that data in.

MS. WILSON: Uh-huh. Yeah.

MR. LYNN: Well, can DMS help us escalate this?

DR. THERIOT: I'm not sure. I'm sitting here thinking about how we can get the data, and I'm not even sure we can get that. Because that's all, you know, over in public health.

But it is an issue, and you're right. I think maybe it has to go higher up than where it's been sitting.

MS. MARSHALL: And I would think Medicaid -- because Medicaid is supporting this program; correct?

MR. LYNN: Right.

MS. MARSHALL: There's dollars coming from Medicaid's budget toward that program. I would think they would want

accountability with what's happening with those dollars and how effective it is.

MS. WILSON: Yeah. And, also, when I was on the ICC committee -- of course, this has been a few years back now, so I don't know what the current status is. But First Steps as a program was in the black. You know, they were not costing the State money. They were bringing money in, you know, part of that being from insurance companies that we have to bill which has always been kind of questionable.

And, you know, what Pam was alluding to is the fact that First Steps is an education-based program, but we're supposed to bill medical insurance for it. But, you know, that's a whole 'nother conversation.

So -- but all that to say, that the State, I would think, would want to -- not only because hopefully they want to support our children, but because this is a program that's not, you know, costing the State money, they would want to keep pushing that and keep finding ways to make it more and more successful. But that is not really what

we have seen play out.

Now, it may look different now on paper because -- I haven't been a part of that group for a number of years now. So I'm not sure what their current status is. But when I left, that's where it was so...

MS. PARKER: That could be something you could make a recommendation for.

MR. LYNN: Yeah. That would be -- maybe we can make a recommendation to the MAC to escalate this and get some of that data.

MS. WILSON: Just let me know when the meeting is, Dale. I'll be there.

MR. LYNN: All right. Okay. The next thing on the agenda --

MS. MARSHALL: Dale, I had one question, sorry, before we go on to a new topic. On that -- back to that KAR 907 8:020, I do not see the reference. I've been going through that, and I don't see the reference to a signed -- it's a physical therapy KAR, and I don't see the reference to the signed physician -- or for the physician to sign the plan of care. So it must be a

different KAR UnitedHealthcare is referring to.

MR. KERN: I apologize. This is Chris Kern with United. Who is speaking?

MS. MARSHALL: This is Pam Marshall.

MR. KERN: Okay. Pam, I will take that back and talk with Dr. Cantor about that, and we'll follow up with you. Is your email address in the chat?

MS. MARSHALL: No. But I can put it in there.

MR. KERN: I appreciate that. And just repeating your question on the KAR, you're not seeing --

MS. MARSHALL: She seemed to state that the requirement of a referring physician signature on the plan of care was located in a KAR, and the reference she gave me was a KAR only for physical therapy. This is PT, OT, and speech in our TAC. So I don't know that that's the correct KAR, so if you all could provide the reference for where that is.

MR. KERN: Yep. Okay. We'll

follow up with you. Thank you for that.

MS. DEROSSETT: And did anybody get the KAR also that she was referring to for the start/stop times?

MS. MARSHALL: Yes, I did. That was 907 040, Section 3, 2.C.3, she said.

MS. DEROSSETT: 2.C.3. Okay. Thank you.

MS. WILSON: Have you checked that one, Pam? Because I wrote 047, but I might have written it wrong. You had 040?

MS. MARSHALL: Uh-huh. No. I haven't checked it yet.

MS. WILSON: I might have written it wrong. It's one of those two. Okay.

MS. DEROSSETT: I did have the 040.

MR. LYNN: Okay. Last item in new business would be the traditional Medicaid and MCO denials of Frazier Rehab's physical and occupational therapy for patients with complex medical and neurological conditions.

And I spoke with Elizabeth Fust. Elizabeth, I hope I'm saying your last name correct.

MS. FUST: You are.

MR. LYNN: And Miranda Garvin about their concerns with these denials they're receiving for PT and OT for these complex medical conditions, and --

MS. GARVIN: Yeah.

MR. LYNN: -- we welcome them to speak about this.

MS. GARVIN: Thank you, Dale. Again, I'm Miranda Garvin. I'm one of the rehab directors at Frazier. I am director of the spinal cord program and the outpatient clinics that oversee care for patients with neurologic and complex medical conditions.

Liz Fust, she is on our Board of Trustees here at Frazier and works with me often in our wellness center. Liz, do you want to introduce yourself?

MS. FUST: I'll just say that I have a spinal cord injury myself and, in addition to being on the Board of Trustees, have been an inpatient, outpatient, and so forth at Frazier Rehab with my chronic neurological condition. I don't know that I can add much, but I'm here if I can and leave it to Miranda to explain this.

MS. GARVIN: Yeah. So thank you for letting us be here today. I really am thankful for the opportunity to just share some of the trends that we're seeing.

Dale, I didn't know. Is it possible for me to share my screen?

MR. LYNN: Is it possible --

MS. BICKERS: Give me one second, and I'll make you a co-host, Miranda.

MS. GARVIN: Okay.

MS. BICKERS: You should be able to now.

MS. GARVIN: All right. So I just have a little bit of information that I wanted to share and then some recommendations. But kind of where this came from, Medicaid and managed Medicaid plans had waived authorizations for therapy visits through the pandemic and resumed authorizations in May. Since then, we've just gradually seen a trend in denials and therapy holds.

So you can see here. When we looked at the patients that are seen with complex medical or neurologic conditions between May

of '22 and this past June, we had a drop in 15 percent of patients with Medicaid and managed Medicaid plans.

And during this time, we had nine particular individuals that I'm focused on, and you'll see their diagnoses here. We have three patients with incomplete tetraplegia, one with complete tetraplegia, three patients post-stroke, one with cervical myelopathy and a brain injury, another one with Klippel-Feil and Down syndrome. And it's -- their payors have been a variety of managed Medicaid plans but also Kentucky Medicaid.

In addition to those nine denials, really, one of the even more complicating factors is the therapy holds and the time it takes for an authorization. So when we admit a patient with a condition like a spinal cord injury, brain injury, or stroke, we're doing an evaluation and then we're scheduling them for consistent therapy. So it might be two, three times a week, PT, OT, and speech therapy, depending on the severity of their needs.

But when they are running out of visits,

we have to place them on hold while we go through the authorization process and cross our fingers, hope that we get the authorization in a timely manner so that the patient can resume therapy.

The wait time right now for Kentucky Medicaid has been about 18 days. We fortunately do not have to exhaust their visits, but our office staff are having to really time out 18 days before they run out of visits to go ahead and start the request for additional visits.

Other complicating factors, which I actually discussed earlier, were when they do get a denial, having to set up a peer-to-peer with the physician is a challenge. Again, that's something that our office staff is having to coordinate with the physician's office staff, send over the records, hope that the physician will read those records, and truly be able to advocate for what that individual needs.

And then lastly, as it relates to these therapy holds, for any of the managed Medicaid plans using the AIM portal, we are

finding that they're only getting three and four visits approved at a time. And for our patients that have these types of conditions, it is not common for them to make significant functional, objective progress in only three or four visits.

So what is happening, we may get three visits approved and then when it's time to request authorization for more visits again, the patient hasn't made a whole lot of change in three visits. So they're getting denied during that time.

I have two cases, just to review. Both were denials, one patient with an incomplete thoracic spinal cord injury from a fall. She had a 20-day inpatient rehab stay at Frazier, and she was denied after 26 outpatient PT visits. This was with CareSource.

This particular individual, I was reviewing her case. She had progressed from her wheelchair to standing activities, initiating steps at the time of her denial. So she was making progress but, nevertheless, was still denied for ongoing visits.

And then in the second case, we have a

36-year-old patient with an acute stroke, a 13-day inpatient rehab stay, and was denied after seven outpatient therapy visits. And there were documented medical complications. This was a patient using Passport by Molina.

The patient did end up getting readmitted to the hospital for some of these secondary conditions. But had we been able to keep them engaged in therapy, perhaps we could have minimized that or prevented them from being readmitted.

But this was a case of only being approved, like, four visits. And, you know, we're waiting for additional visits, or they didn't make progress because of these complicating factors.

So ultimately, just recommendations to see if this is feasible. When we are looking at patients with complex medical or neurologic conditions --

(Brief interruption.)

MS. GARVIN: I'm sorry. We have an overhead.

For patients to be approved at least ten sessions at a time, an approval for three or

four visits for these types of conditions, it's -- there's seldom progress made, at least functional and objective progress. For authorizations to be given within 48 hours of submission, waiting days to weeks is -- causes a gap in that patient's care.

And then lastly, as I discussed earlier, for the peer-to-peers to take place between therapists and not trying to coordinate that between physicians. The individuals who are directly and intimately involved in the care should be able to advocate and speak on behalf of that patient's progress and what is needed.

So thank you for allowing me to share that. This is something that -- you know, we are operating our clinic off of being able to provide care for these patients, and we want to be able to advocate and serve them in a way that helps them to recover as much as they can.

MS. BICKERS: Miranda, would you be so kind to email that to me, so I could send it out to the group?

MS. GARVIN: Yeah.

MS. BICKERS: Also, we had a director that had to drop, but if you have any fee-for-service Medicaid patients that are having these denials, could you please send those to me as an example so I could send those over and have Medicaid look --

MS. GARVIN: Sure.

MS. BICKERS: -- at their portion? Thank you.

MS. GARVIN: Sure. And who is speaking? I'm sorry.

MS. BICKERS: Oh, I'm sorry. My name is Erin Bickers. I'll drop my name and email in the chat.

MS. GARVIN: Thank you. And, really, if there is anyone else that we can talk to to escalate this. You know, our team, we are writing letters of medical necessity. We are documenting long and short-term goals. We're really focused on using a variety of functional outcome measures to be able to show that progress is being made. And when complications do arise, that we are documenting those.

So I would love to be able to just

continue the dialogue on how to resolve those.

MS. BICKERS: When you email me as well, Miranda, I can send you the list of the MCOs that are on the call today. They've been dropping their emails in the chat, so I'll share that with you as well.

MS. GARVIN: Perfect.

MS. MARSHALL: This is Pam Marshall. I just wanted to add, Miranda -- thank you for sharing that -- is as providers in Kentucky, because we really have so many forms of Medicaid, different MCOs and fee-for-service Medicaid, they all have different processes. And they're all measuring their own data separately.

So what is challenging that I'd like Kentucky Medicaid to consider is exactly what Miranda presented. It's a cumulative effect that happens to the provider; right?

You know, a physician can come on here and say, well, we don't see very many denials for UnitedHealthcare or for, you know, Anthem Medicaid or whatever, for your practice. But as a whole, the denials are coming from all

of the different payors.

So it is a cumulative effect that we feel as providers, that we're unable to provide the service because of, you know, the PA is moving too slowly or, you know, whatever the nonpayment issues are. Then you have it, you know, across multiple payors, and it just becomes a mountain, like a mountain to overcome.

MS. GARVIN: Right. And -- well, thank you for sharing that. What I mentioned, we had 75 just in those three months, 75 therapy holds. So when you think of just a business operations, I mean, first and foremost, we want to take care of the patient. But that's 75 unfilled therapy sessions.

We may have been able to plug in an eval or tried to think strategically as a team to keep everybody productive during that time. But we didn't want to fill that ongoing slot because we want -- we are planning and hoping that that patient will get authorization so that we can continue their care. So just the burden from operations of having to hold

therapy, and 75 in just a short time, you know, that really is not good for our operations.

And I do just want to elaborate. I think another thing to consider with some of these complex conditions, the inpatient length of stay that I referenced here is shorter and shorter and shorter. And that's something that we, as therapists and rehab in general, have seen over the last several years.

But as that gets shorter, the need for outpatient therapy becomes evermore essential and critical, even for just education on how to live with a spinal cord injury or how to navigate within your community. So 10, even 20 visits, it's just -- it's simply not enough for those with these complicated conditions.

MS. DEROSSETT: And to tie in to what you said also about trying to get more visits approved at the first part. Because if you only get three to four visits and it's taking a long time to get approval, you have to send in for the approval, or you're going

to automatically have that delay. (Audio glitch) on hold before you can get the approvals back again.

And you're not being able to show the progress because if you only have four visits, you're going to have to send in the approval by the second visit, and you won't have anything to show.

MR. LYNN: Yeah. I agree with that.

MS. FUST: Dale --

MR. LYNN: Erin, I think I -- I'm pretty sure, Erin, I sent the presentation that Miranda had to you along with the minutes -- not the minutes, the agenda for today's meeting.

MS. BICKERS: Okay. I'll double-check my records. Thank you, Dale.

MS. GARVIN: Thank you, again.

MS. FUST: Dale, I wonder if I could ask a question if it wouldn't be too much of a bother.

MR. LYNN: Go ahead.

MS. FUST: What -- how does this committee determine what to answer -- what

questions or issues to answer within the committee and which to send to the MAC? Just as a consumer, I'm interested in that.

MR. LYNN: Well, in this case, I think that this committee is, you know, forwarding your information to all the MCOs and DMS, and hopefully it'll resolve the concern that you have. And if it doesn't, then we may escalate it to the MAC.

MS. FUST: Thanks.

MS. WILSON: Dale, I had a couple of things for traditional Medicaid.

MR. LYNN: Sure.

MS. WILSON: Okay. So we're having an issue with -- reassessments that are done on a Friday are having to be signed by Saturday for traditional Medicaid. So Saturday being a non-working day, that's obviously a problem. So, you know, someone does an eval, re-eval on Friday afternoon at 4:00, you know, they're not going to have it done by Saturday. So I guess that's -- that's one thing that I'm curious --

MS. MARSHALL: Kresta, can I ask where you got that from? Because we have

something different in writing that the weekends don't count. So what are they -- or what is your understanding of why that has to be done in 24 hours?

MS. WILSON: That's, I guess, what's happening with denials. I'm going to have to double-check with my billing manager to see, like, specifically.

MS. MARSHALL: Okay.

MS. WILSON: But that was one thing she said was an issue.

MS. MARSHALL: Because the regulation says 48 hours. We had that changed a couple of years ago. Because that documentation has to be signed off within 48 hours.

And one of the problems we addressed with prior authorization is that we're allowed 48 hours to get that document completed, and the weekend hours don't count. That's what I've been told. It's not a business day.

So if you saw a child or a patient at 4:00 on Friday, you would have until 4:00 on Tuesday. That would be the 48-hour.

MS. WILSON: Yeah. Maybe it's, like, a glitch in the system. You know, it's something that's just not -- it's kicking it back, you know, could be.

But who do I need to send specific questions about traditional Medicaid to?

MS. BICKERS: You can send that to me, if you'd like, Kresta. This is Erin. And I can get it over to the appropriate place to get in contact with you.

MS. WILSON: Okay. Great. I'll see if she has specific things that she's getting back on that.

And then the other thing I was curious about, we had talked about this a little bit in maybe the last meeting, or the one before, about no-shows and tracking those for Medicaid. I was curious if you all had -- and I know you all set up the portal thing to go in and for us to put that information in when we have a no-show.

Have you all done anything yet with that data, or how much data are you even getting? It's a little time-consuming, putting it in, but, you know, we're willing to make the

effort if we feel like, you know, okay -- what are we doing with the information, I guess, is what I'm getting at.

MS. BICKERS: I believe Angie Parker had to drop for another call, but if you could send that to me, I'll get that over to her and follow up with you.

MS. WILSON: Okay.

MS. BICKERS: I know we've had a lot of questions about the no-show data and concerns about it being time-consuming for the providers.

MS. WILSON: Yeah. Yeah. Okay. Thank you.

MR. LYNN: Yeah. And I do remember whenever Mr. Miller was the commissioner, the time frame on the signatures on documents was 24 hours, and it did get increased to 48 hours. But it would be nice if it was increased to four days.

I don't think there's anything in the regulation that says anything about the weekends not counting, but maybe I'll have to look at that.

I think we have Camille Skubik-Peplaski

on the call. I think she had a question she wanted to ask.

MS. SKUBIK-PEPLASKI: Yes. I'm here.

MR. LYNN: Are you still on?

MS. SKUBIK-PEPLASKI: Dale, I'm here. Thank you very much for hearing me at this meeting. I'm representing the Kentucky Occupational Therapy Association. And as an association, we're concerned about the crisis for behavioral and mental health.

So to improve our mission to educate consumers and providers, we would like some information so that we can decrease restraint reductions, lead to trauma-informed therapy methods, and keep clients in least-restrictive environments.

So we were asking if we could receive some information to help us with this process, and the first thing that we are requesting from Medicaid from MAP 650 data for -- broken down by county, if possible: Was the -- what's the primary diagnosis and the secondary diagnosis of children that are receiving occupational therapy?

Of those requesting, again, occupational therapy services, how many per county were approved, and how many were denied? And this could demonstrate the need for education on codings of clients in need of services can more easily access it.

And of those denied or approved, how many occupational therapy services included in that approval or denial by county?

And last thing that we're requesting is for clients that go through a recertification, how many per county were approved, and how many per county were denied? This would allow us to better serve Kentuckians. Thank you.

MS. BICKERS: If one of the committee members -- I'm sorry. This is Erin again with Medicaid. If one of the committee members can make that a formal data request and send it to me in writing, I'm sure we would be happy to try to pull as much of that as we could.

MR. LYNN: Okay. I'll make that request, and I will send that to you in writing. Thank you, Erin.

MS. SKUBIK-PEPLASKI: Thank you, Dale. I will forward it to you. Thank you.

MR. LYNN: Thank you. Are there any other issues the TAC members may have?

MS. MARSHALL: Dale, what -- this is Pam Marshall again. What is the update on the credentialing, moving the universal credentialing forward? Again, this is a cumulative-effect issue for all providers in Kentucky, as many of us have unpaid claims or wrongly-paid claims that go on for a long time because of the lengthy time it takes. And it's cumulative over -- across all the payors, all the Medicaid payors. Do you know the update on that?

MR. LYNN: I do not. You know, what can we do to make them more streamlined? I think it would be appropriate that once Medicaid credentials somebody, that it should go straight through all the MCOs, and they shouldn't have to do their own credentialing process. That's just my take on it.

MS. BICKERS: Jennifer, are you on the call?

MS. DUDINSKIE: I'm on. I was just

going to speak up. So some time ago, there was some legislation that was posed for a single credentialing agent. And unfortunately, that did not go through. So, you know, at this time, it's not an option for us to be able to do it that way.

I do know that several of the MCOs use a credentialing agent that some of them have in common. I know that on at least one of the other TACs, that's come up in conversation. I don't know if any of the MCOs want to speak to that today.

But there were some efforts in place, I think, to try to streamline a little bit of that with the MCOs so that if you are credentialing with one MCO, you could credential with multiple MCOs that were participating with that single entity.

But as far as the DMS side, you know, we have our own credentialing process. Every provider has to go through the fee-for-service credentialing process with us first before they're allowed to credential with an MCO. And right now, that's just the process we have to follow.

Is there anybody on with the MCOs that wants to speak to your all's credentialing process?

MR. LYNN: Yeah. It sure would be nice if they just -- once Medicaid credentialed a therapist, that it can go straight on through all the MCOs and not have to take three months. It's an extreme burden on small practices, for sure.

MR. KERN: This is Chris Kern with United. I can't speak to the universal credentialing. But if there are some specific credentialing issues that providers are having with United, I'd be happy to take those examples. My email address is in the chat. Please feel free to share with me what your concerns are with specific examples, and I will get you answers.

MS. DUDINSKIE: And I echo that from the fee-for-service side. And if there's anything we can do to assist, if somebody is having difficulties, we are happy to try to help and work with the MCOs, but I would need specific examples for that.

MS. MARSHALL: Yeah. We've --

because the staff on this TAC -- this is Pam Marshall talking again. We've been working on this since the expansion of Medicaid of 2014. This has been a problem since then. We've been providers. Nothing has changed.

We have such a high volume of -- I mean, it's just -- it's one of our largest challenges because therapists aren't a -- we're a pretty low-risk provider type. Yet, you know, the credentialing process is all different.

So when you think of a practice, a provider, any therapy provider in Kentucky, if they're going to serve children, you really, you know, almost want to be in network with all the different payors so you can serve them best.

Because many children have commercial as primary, and they have a Medicaid as secondary. And there's all different, you know, Medicaids, as we've been discussing.

And, therefore, every single payor has a different process, a different credentialing process, a different timeline.

It used to be that Medicaid, you know,

there for a while, was issuing Medicaid IDs fairly quickly. Now it's slowed down again. And the reality of trying to hire several months out, it's very difficult to do.

I know with physicians, that's a different story. Physicians and providers that are, you know, writing scripts and have a much higher level of scrutiny, you can understand that that's why credentialing takes six months to a year, much longer for those providers.

But for our provider type, we really ought to be able to get credentialed within 30 days and not have this drawn out. And we -- we often go beyond the 90 days.

And so in that amount of time, as a small provider, you don't have the option to wait to send those claims out because you need some income coming in. You've already hired this person.

You know, we try to hire 60 days out, but that's even a challenge because we're primarily a female industry. And people have babies, and people move and -- you know, things happen, and you have to hire new

providers.

And getting that caseload -- you know, not having all those children sit and go without therapy, you want to start that new therapist, so there's not a gap in their progress.

And the challenge with credentialing is it doesn't allow us to continue those children's therapy progress because we're so burdened with trying to get the credentialing done.

And then when we do have it completed, then it's hundreds and hundreds and thousands of claims that are paid incorrectly. And it's just years of trying to get those claims paid correctly.

Because, you know, they'll complete a project, and out of that project, there's a 10, 15 percent fallout, and then you're trying to get those claims.

So that leads me to my next question, is: Who in DMS -- who in Kentucky Medicaid can help therapy providers when we have unpaid claims that aren't our fault or our issue? And we've done all the necessary

steps.

I used to bring claims to Charles Douglas, but now that he is retired, I don't know who that is that helps us with those difficult cases.

So I guess that's two questions. One, that's just painting a picture of what a burden this issue is. And then, two: Who is it in DMS that can help us with those extenuating circumstances?

MS. DUDINSKIE: So this is Jennifer with Program Integrity. So in regard to the credentialing problems that you're having, if you could send me specific examples of the time frame being beyond 90 days or, you know, show me examples of what the issues are with that taking so long, I can take a look at that on my end and see what might be going on. Try to nail down that part of it.

MS. MARSHALL: I have another suggestion, simply because we do file complaints when it's past that 90-day. But my suggestion is, why not require the MCOs to submit data to you all of the volume of claims for therapy services that go unpaid or

paid out of network. I mean, it's a huge -- you need to look at that, at the whole state, the number of claims that are denied for those reasons. That's where you'll get the full picture.

MS. DUDINSKIE: So, Erin, you might want to make a note of that for MCO, for it to take a look at. In terms of the unpaid claims, and we're speaking of Charles Douglas, that is in a different division. I don't know if Justin Dearinger is on. That would be his division. I'm not sure specifically which person could help. But if nobody from that area is on today, Erin can relay that message to that team as well.

MS. MARSHALL: Yeah. I would really like someone to send me an email of a name and a person to work with. Because I've tried to reach out to Program Integrity --

MS. DUDINSKIE: Well, I'm Program Integrity, but we don't do claims. We just do the credentialing fees, so the --

MS. MARSHALL: Right. I know. I was trying to reach out to get connected to someone.

MS. DUDINSKIE: I see. Okay.

MS. BICKERS: If you email me, I can put you in contact with the Provider Complaints group that is in Angie -- I believe that's still under Angie Parker's group, and she had to fall off. And I can get you the email address of the correct person to send those issues to to look into those unpaid claims.

MS. MARSHALL: Okay.

MS. BICKERS: And I can drop my email address in the chat again.

MS. MARSHALL: Yeah. If you could do that, that would be great.

MS. PULLEN: This is Kelly Pullen with Aetna. I could not come off mute fast enough, so I apologize. But I think Jennifer was referencing, in terms of credentialing, there are a couple of MCOs that are participating in a project with Aperture which is intended to really streamline that credentialing process. That is being done in partnership with KHA, and they did come and actually present to the Behavioral Health TAC, I think, at their last meeting.

So I just wanted to make that connection for folks, that -- if that would be helpful. I know KHA came to the BH TAC to present on that particular project, and I'm sure they would be happy to come to this TAC as well and make that presentation.

MR. LYNN: Yeah. That might be a pretty good idea.

MS. WILSON: One more question that I'm sure everybody wants to know the answer to, and that is: When can we expect to see the fee schedule for 2023?

MR. LYNN: Hopefully before March.

MS. WILSON: I would like it before April.

MS. FAWVER: Hi. This is Marci Fawver, and I am a provider for OT, PT, and speech therapy. We also experienced recoupment or adjustments to our claims that we billed this year from January to mid-February, where our claims were adjusted to the 2020 rates.

We had billed at the 2021 rate. We didn't get the fee schedule till mid-February and then we had that money taken back. I'm

assuming other providers experienced that as well.

MR. LYNN: I'm not aware of that.

MS. FAWVER: Okay. Well, I -- it did happen to us, and it's happened to other agencies similar to us. So we provide services to adults with intellectual disabilities. So yes, our claims were adjusted back to January 1st, 2022, to reflect the 2022 rate, which most rates went down.

However, the rates that did go up, like sensory, were not adjusted to reflect the increased rate. They only adjusted down, which has never happened before.

So I would like to hear from somebody from Medicaid about why that occurred, and should we expect that again in 2023 when there's a delay in the release of this physician fee schedule?

Because we pay our therapists based off that rate and then to have that money taken back after we've already contracted with therapists to provide services at a certain rate.

MR. LYNN: That's a good question.

MS. MARSHALL: Yeah. And this is Pam Marshall again. And we are set to get a four-percent cut again, and that is -- that is happening. I don't see anything stopping that at the CMS level. So since the Kentucky Medicaid fee schedule is built off of a percentage of CMS, we will see cuts again exactly like last year.

MS. FAWVER: Is there anyone here that can speak to the retroactive implementation of the fee schedule this year and having that money taken away?

MS. BICKERS: Is anyone from policy on today?

MS. HOFFMANN: Erin, this is Leslie. I don't see -- I can't tell if Justin is on or not, but we can definitely send a follow-up to him.

MS. BICKERS: Thank you, Leslie.

MR. LYNN: Okay. Recommendations for the TAC would be -- I mean, rather, for the MAC would be some data about First Steps. I think that's the only recommendation. Is that correct, Kresta, and the rest of the TAC

members?

DR. THERIOT: I think the data request was something separate, but the recommendation to the MAC had to do with, you know, First Steps and -- I can't say it. Kresta could say it better. And looking into the training, the coaching model and things like that.

MS. BICKERS: Yes, Dr. Theriot. I believe you're correct. And then the data request is just the formal request from the committee to Medicaid, to pull some data for you guys to review.

MR. LYNN: Okay. Thank you, Dr. Theriot.

Okay. The next meeting is Tuesday, January 10th, and I'll adjourn this meeting.

MS. BICKERS: And the next MAC meeting is November 17th, for anyone who wants to attend.

MR. LYNN: Okay. Thank you.

DR. THERIOT: Hey, Erin, does Dale have to do the specific wording for the recommendation before they leave?

MS. BICKERS: Yes. The

recommendation needs to be voted on. So if Kresta wants to -- since, I believe, she was the one that brought it to the table, if she wants to make the motion to have that recommendation sent to the MAC and then the rest of the members can vote. You still have a quorum. Even though Emily had to drop for another call, you still have three.

MR. LYNN: Right. I don't see Kresta on here.

MS. BICKERS: It looks like a few people went ahead and dropped. Dale, you may need to put that on the agenda for next time, to make that recommendation if you don't have a quorum still. My apologies.

MR. LYNN: I don't think I do, so that's what we'll do. We'll put it on the next agenda for January and go from there. All right. Thank you.

MS. BICKERS: Thank you, everyone. Have a great day.

DR. THERIOT: Thank you.

(Meeting adjourned at 10:02 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 7th day of November, 2022.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR