DEPARTMENT OF MEDICAID SERVICES
THERAPY TECHNICAL ADVISORY COMMITTEE

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NOVEMBER 12, 2024
8:30 A.M.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

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 Derossett

MS. BICKERS: Good morning. It is 8:30. We are still clearing out the waiting room. I saw Dale, Linda. Did I miss any other TAC members logging in?

Good morning. Can anybody hear me?

MR. DEARINGER: Yes, I can hear you.

MS. BICKERS: Okay. Just making sure. It is very quiet this morning.

MR. LYNN: I can hear you, Erin. I was looking through the list here to see if any of the TAC members are on there. Just myself and Linda.

MS. BICKERS: If you would like to, we can give it just a moment longer. I know at least for us, it is coming back from a three-day weekend so my computer was a little slow getting started this morning.

The waiting room is clear. If you want to go ahead and begin, I can let you know if we have any other TAC members join us.

MR. LYNN: Okay. I will start

with old business.

As far as reviewing the approval of the September minutes, we have to wait until we get a quorum.

MS. BICKERS: Yes. It looks like Emily is logging in now.

MR. LYNN: Okay. Good.

So old business. Follow up from the Department of Medicaid Services regarding the OT PT fee schedule. Are there any changes in that?

MR. DEARINGER: This is Justin Dearinger.

Currently there are no changes with that, at this time.

MR. LYNN: So I think I understand that you have someone doing a study on that; is that right?

MR. DEARINGER: Yes, sir. We started that, I think it was a little bit ago and we started that doing a study on just the basic fee schedule. So the fee schedule that we pay, OT PT and speech, and that morphed into a bigger study and, of course that study, we had actually

started that study right before there was some legislation done to where we had to perform a separate type of study through that legislation.

So it kind of changed how we had to do that and submit that to the legislature.

After we submitted that, we continued on with our initial research and then we got in to the fact that we had differences in what we were paying, state plan services, EPSTP providers versus waiver providers, and that became very difficult.

And the reason was that the waiver codes were different than any of the other codes, so they were all separate, and then we had some unique challenges with EPSPT as well, so we had to go over all of those different things in multiple different ways, came up with multiple scenarios. We still have a few outstanding things that we are putting together.

And then as you all know, we had

the budget come out. When the budget came out, there was no increase this year for any codes or reimbursements, and so that wasn't a possibility for this year.

For next year, they had allocated $25 million total for all of Medicaid, and with the caveat in the legislature that the Legislative Research Commission would decide where that went.

So we had multiple studies out with multiple different schedules, so we have been submitting that to the Legislative Research Commission and are waiting on their decision on what they are going to do with that. So that is where we are right now with that study.

MR. LYNN: Thank you, Justin.

MS. BICKERS: Dale, I want you to know that Kresta has joined us, so you know have a quorum.

MR. LYNN: I see that.

Has everyone reviewed the September 10th minutes and can we vote on approving those?

MS. SACCA: Dale, I will move to

approve the minutes.

MR. LYNN: Thank you, Emily.

Kresta, do you want to second that?

MS. WILSON: Yes. I will second that.

Question for Justin. When will we know as far as that, how that money is allocated? Is there a ballpark timeline of when that might be, what month?

MR. DEARINGER: The Legislative Research Commission actually has given us a timeframe, so we are trying to stay in communication with them to see when they would let us know.

Of course, we would have to make system changes and other changes and notify providers, so I haven't got any dates from them or any estimates from them at this time. As soon we know, we will let our providers know.

MS. WILSON: As far as the fee schedule for 2025, is it remaining the same?

MR. DEARINGER: We haven't got

confirmation back fully on that. As of right now, I am not sure whether it will stay exactly the same.

It won't stay exactly the same obviously, but I think what you are asking is will there be any codes that decrease, and I don't have full confirmation back on that yet.

We should have that back sometime in the month of November. Once we know that, we will reach out and let the TAC know for sure.

MS. WILSON: Okay. Thank you.

MS. MARSHALL: I have a question related to that, but I'm not sure if now is the time to ask or if I need to wait.

MR. LYNN: If it is related to that, Pam, that it will be fine.

MS. MARSHALL: Okay, great.

So CMS is proposing another 3 percent cut, so if we could ask what we asked last year, which was to keep the fee schedule the same and not base it on that cut. So we are asking to not have that, something between 2.8-something to

3 percent. You know, it is part of that CMS balanced-budget cutting some of our CPT codes.

MR. DEARINGER: Again, there are a few cuts for multiple providers so we've made that request to see what we are doing with those, and as of right now we have not got confirmation back. But as soon as we know, we will let providers know.

Again, we should know something this month because we usually try to have those done and out by January if we can, and if not then, at least by February.

Sometimes CMS doesn't get us their full codes until sometime in January.

MR. LYNN: All right.

The second item on old business would be following the initial 20 visits, Passport is authorizing five to eight visits for a nine-day period.

Has anything been resolved on that? They are using rehabilitation guidelines and disregarding habilitation guidelines?

MR. TEICHMAN: This is Jeb Teichman, CMO for Passport by Molina. I can answer that question for you.

MR. LYNN: Thank you, Jeb.

MR. TEICHMAN: We rolled out a -- we took a closer look at therapy services for chronic pediatric conditions that we were approving back in August and noticed an increase in utilization.

I will admit that the process we rolled out was a little clunkier and we have made some corrections.

The issue is not medical necessity for these services, it is frequency. We were using a table in MCG that wasn't serving the purpose for the providers so we changed that and have now changed the process to look a little bit more closely at these requests and we are now approving more than five to eight visits in a 90-day period.

MR. LYNN: Okay. That sounds good. So a positive change there.

MS. MARSHALL: What is the criteria for determining that frequency?

MR. TEICHMAN: We have done a lot of research on this. I have talked to pediatric physiatrists and we are unable to find any kind of industry standard for frequency of visits for these conditions.

If your society has such guidelines, I would love to see them. I will put my email in the chat and, if you would like to send it to me, I would totally appreciate that.

MR. LYNN: All right.

The next item was translation services no longer being provided by the MCOs. I kind of looked into that myself, and I think that is not really a problem. It seems to me like the MCOs are providing translation services.

Does anybody see a problem with that?

MR. OWEN: Good morning. This is Stuart Owen with WellCare.

We absolutely do pay for them. I don't know if that is because a few months ago DMS started talking about a single line for everybody to call and that

morphed into that the MCOs were not doing it anymore, but we are.

MR. LYNN: I kind of thought that. I know that we practiced them with -- we use translation services and all of the MCOs seem to be providing that for us.

MR. OWEN: We do.

MR. LYNN: The next item would be the diagnostic codes to bypass prior authorization requirements after 20 visit limits.

How is that list going? It looks like it is probably expanded more than what I have on this.

MR. DEARINGER: Yes. We have picked up a few more that we have added and so we are finalizing right now. We still have to go over that list with a few other partners that we are currently using for this project, so it is not finalized yet.

If you all have time to continue to review it, you still have the time, but we hope to have this project wrapped up in

January and rolled out by the end, so that is kind of our goal. We are working hard to get that done.

We are currently waiting on some of our other partners' reviews and looking into that, and we think we will have that done and rolled out by January.

We already have that in our system ready to go, and we still have to meet with our MCO partners on that and do some other things with our partners before we finalize the list and move forward, but we are kind of excited by this and hoping that it will reduce the burden for you all as providers, the burden for members, and give a little bit more clarity to that system.

MR. LYNN: Sounds good. It will make things easier for providers and the MCOs, too.

New business. Aetna Medicaid taking long for a new provider to be added. I think Kresta had a concern about that.

MS. WILSON: I think that was

maybe an older one that got left on there.

It fluctuates, you know, how it is sometimes quicker than others, but the issue -- not paying claims because providers aren't being added.

We have reached out to our provider rep, but we get no response. I think anybody, Aetna, let us know what would be the best way to reach out if our rep isn't responding to us.

MS. RISNER: Kresta, this is Krystal with Aetna. I actually spoke to the provider rep last week, just checking in to make sure everything looked good, and she had spoke -- I don't recall the lady's name who works with you -- but she had a concern that had already been addressed, but the rep's name is Becky Bowman.

MS. WILSON: Right. So if Becky doesn't respond, should we reach out to you?

MS. RISNER: Yes. That would be fine.

MS. WILSON: Can you make sure

that you put your email in the chat for me?

MS. RISNER: Yes.

MS. WILSON: Thank you.

MR. LYNN: United Healthcare Medicaid denying claims for no authorization when the authorization is on the claim.

MS. WILSON: Yes. This is a reoccurring issue, and it is an administrative burden. Basically in the time that it takes to keep resubmitting things, even though the information is there, they eventually seem to get approved, but it is taking months, you know, to get it straightened out and we don't know why it keeps happening.

I don't know if this is a pattern for other people or if it is just us.

MR. LYNN: Anybody else on this meeting that has had that problem?

MS. WILSON: I guess, what is the issue? If anybody from UHC can speak to what might be the problem.

MR. IRBY: Yeah, this is Greg. I am our COO here. Can you all hear me?

MS. WILSON: Yes.

MR. IRBY: I saw this on the agenda and I had actually reached out ahead and asked if there were any examples of this. I wasn't able to get any.

We just wanted to talk through it here, but it is concerning for me to hear that. I want to make sure I understand the problem, and then maybe off-line we can get some examples.

You are saying that we are denying a claim for no authorization, so you are saying you are getting a denial saying this claim is not authorized, however, the service has already been authorized, like you have already got the authorization approved?

MS. WILSON: Yes. And the authorization number is on the claim.

MR. IRBY: Okay.

MS. WILSON: I can get you examples if you want to send me or put your email in the chat, and I can send you

those. My billing manager can send those to you.

MR. IRBY: Okay.

MS. WILSON: Thank you.

MR. IRBY: No. Thank you. That is definitely not the way our system is intended to work, so I don't know what the nuance is that is creating that.

MS. WILSON: Sure.

MR. LYNN: All right. The next item is WellCare is not paying CPT code 925264 OT. I am not sure who had a concern about that.

MS. MARSHALL: I can speak to that. 92526 is on both the speech and the OT schedules, but when OT bills it, it denies for a DN-001 prior authorization required but not obtained, even though the prior authorization has been obtained and it is on the claim.

Then service 92526 requires a prior auth, however no valid authorization can be located, is what the denial says. But, you know, per the claims analyst and EviCore representative, code 92526 is not

a covered code on the OT family and substitution list.

So it seems to be a problem between EviCore and WellCare not having that code loaded properly for the OT fee schedule. It is not in the UM policy, it is nowhere stated that it would not be a covered code, and we just keep going in circles. So I don't know if WellCare can speak to that.

MR. OWEN: Yes. Good morning to you, Pam. We are remedying the problem.

Long story short, the subcontractor did not recognize it as OT. Clearly it is because it is on the OT fee schedule. We have issued the directive. We are in the process of changing claims, configuration, business rules for them to recognize that, and so that is in the works.

And we are aware that it was a problem, and I apologize.

MS. MARSHALL: Thank you.

MR. LYNN: Okay. The last item was already addressed earlier with the EMS

question about CMS reducing fee schedule.

Are there any other issues from the TAC members or the public that we would like to address?

MS. WILSON: Hey, Dale, do we need to officially approve the dates for 2025? I know Erin had sent those out. Is that something that we need to do here or can we just email and say that they are good?

MR. LYNN: We could probably approve those.

MS. BICKERS: Do you also mind to go back and officially vote for the minutes? We got a first and a second, but we didn't officially vote as well.

MR. LYNN: I apologize.

MS. BICKERS: Just for the record. No worries.

MR. LYNN: Yes. Can we get a full vote on that? The September minutes. Emily, Kresta, Linda?

MS. WILSON: Vote to approve.

MS. BICKERS: Thank you.

MR. LYNN: Are there any other

issues the TAC needs to address or the public?

MS. BICKERS: Would you like me to read the 2025 meeting dates for approval?

MR. LYNN: Sure.

MS. BICKERS: I have January 14th, March 11th, May 13th, July 8th, September 9th, and November 4th.

MS. SACCA: I will make a motion to approve those days for 2025.

MS. WILSON: I will second.

MR. LYNN: Can we have a vote on that?

MS. DEROSSETT: I approve.

MS. BICKERS: Thank you. We will get those meeting invites out to you shortly.

MR. LYNN: It looks like we don't have any recommendations to the MAC. I will attend the MAC meeting.

The next meeting is January 14th, 2025. I appreciate everybody being here at this meeting and all of the representatives from the MCOs and

Medicaid. And if there are any veterans in this group, thank you for your service.

MS. WILSON: Thank you.

MS. BICKERS: Thank you.

MR. LYNN: This meeting is 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 19th day of November, 2024.

/s/Stefanie L. Sweet

Stefanie L. Sweet, CVR, RCP-M