COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: THERAPY SERVICES TECHNICAL ADVISORY COMMITTEE

March 1, 2022
8:30 A.M.
(All Participants Appear Via Zoom or Telephonically)

APPEARANCES

Beth Ennis
CHAIR

Dale Lynn
Kresta Wilson
Emily Sacca
Linda Derossett
Renea Sagaser
TAC MEMBERS PRESENT

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APPEARANCES
(Continued)

Leslie Hoffmann
Lee Guice
Angie Parker
Judy Theriot
Erin Bickers
Jennifer Dudinskie
Jonathan Scott
MEDICAID SERVICES

Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

Review and approval of January Minutes

Old Business:

1. 2021 Fee Schedule: any concerns with the process from TAC members? update on reprocessing projects from MCOs?

2. 2022 feeschedule: https://www.apta.org/article/2022/01/07/medicare-payment-changes-2022. Has fee schedule been posted yet?

New Business:

1. Can 92606 non-speech generating AAC be added to the SLP schedule?
2. Wellcare does not allow speech evaluations and treatment on the same day
3. Access Issues: more related to authorization – when few visits are authorized and it takes time to get others, patients don't return. Any other access issues noted?
4. What is the process to request a fee schedule increase?

Other issues from members and public

Recommendations to MAC

DR. ENNIS: My apologies, guys. I'm sorry. I am in my car. Can you guys hear me okay?

MS. BICKERS: Yes.

DR. ENNIS: Okay. I apologize. It has been a morning. The announcement yesterday kind of knocked everybody for a loop and has people scrambling to figure out what spaces are allowed to not mask anymore. So, that's been my morning.

So, we have TAC members on. I apologize. I'm on my car phone, so, it's hard for me to see the screen.

MS. BICKERS: It looks like we have Linda, Dale, you, Renea, Kresta and Emily. I think that's all of you guys, right?

DR. ENNIS: I just turned my camera on so that I'm legal but you guys are going to watch me drive. So, I apologize for that.

Did everyone get a chance to look at the minutes from January's meeting?

MR. LYNN: Yes, I did.

DR. ENNIS: Any changes to those at all?

MR. LYNN: I didn't see any.

DR. ENNIS: Anybody else?

MS. SACCA: No issues.

DR. ENNIS: Okay. Can we approve those as written, then? Yes.

MR. LYNN: I move to approve the minutes.

DR. ENNIS: Thanks, guys. Appreciate it.

When I submitted the agenda items, the schedule had not been posted yet. So, we're in that interim ten days it has. And has anyone had a chance to check the schedule?

MR. LYNN: I have not. I just realized it did get posted, didn't it?

DR. ENNIS: I would say at this point, we're trying to figure out what the actual Medicare rates are. So, I know that it is an adjustment from last year in the positive.

But right now, let's just make sure that the codes we need are on there, that all the codes from last year got transferred over and we'll continue to look at rates and make sure that got put on appropriately as we move forward. Does that sound okay?

MS. WILSON: All the codes were there that we use, Beth, but I realize that some

people may use different ones.

DR. ENNIS: And I know we usually have community members on these calls as well. So, I'm going to ask you guys to be keeping your eyes open and let me knows if there have been codes that have dropped off. Just reach out to one of the TAC members and let us know.

And I appreciate the Cabinet getting that fee schedule up sooner rather than later this year. I know it's a heavy lift and we appreciate it.

Moving into New Business, there was a request for a speech code to be added related to none-speech-generating devices. I guess I'm going to throw that out.

Lee, I don't know if you're on the call. Again, I apologize. I've got a very limited view on my phone here.

Do we need to submit something specific to ask for that to be added or is asking right now good enough?

MS. PARKER: It doesn't appear Lee is on the call.

DR. ENNIS: Okay. Then, I will reach out to Lee and see if that can be added, Dale.

I've got a little blurb written that can talk about the usage of it. So, I will submit that to her.

MS. PARKER: She just joined.

DR. ENNIS: Lee, were your ears burning?

MS. GUICE: Yes, a little bit which helps me remember that I needed to jump on this call while I'm trying to get my computer to connect.

DR. ENNIS: You and I are both having that kind of a day. So, I got on at about 8:33. So, I understand completely.

We are on our first item of New Business and asking for a code to be added to the speech schedule. Do we need to submit anything formal for that or is this request formal enough?

MS. GUICE: Can you tell me why we need to add this to the schedule?

DR. ENNIS: Sure. Sure. So, 92606 is for augmentation and alternative communication. It's a non-speech-generating device code, and a lot of our kids will start working with communication devices like picture boards and things like that that don't generate sound but that do start that communication process. And this is the code that gets used when that is being developed in

session.

MS. GUICE: Is it a new service or just a new code?

DR. ENNIS: It is a code that's been in existence for a while. It just has not been on our schedule.

MS. GUICE: We'll have to take a look at it and do some review on the fiscal impact since it would be a new service actually, right?

DR. ENNIS: I think it would probably be a more accurate billing of an already existing service.

MS. LYNN: Yeah, that's more like it, Beth.

MS. WILSON: It's probably being billed as 92507 because there is no other code that would fit it.

DR. ENNIS: And, Lee, I'm happy to email you details.

MS. GUICE: Okay. That would be great.

DR. ENNIS: I will get that done as soon as I get out of the car.

So, the next item, we received word that WellCare was not allowing speech evaluation

and treatment on the same day and I thought we had worked through that. So, I'm just requesting some verification from WellCare.

MR. MINGUS: This is Jay with WellCare. I checked with our UM Department yesterday and they confirmed that is the case where the eval and treatment is not allowed on the same day.

So, I'm glad to take any examples or any summaries of the situation and the issues and causes back to the UM team for further review but I did confirm that is the way we are doing it currently.

DR. ENNIS: Okay, because part of what we worked through several years ago is the fact that if you can't do some treatment on that evaluation day, it is very difficult to get folks back, especially when you are in processes taking several days to get prior auths for subsequent visits.

And, so, I thought we had worked out that eval and treatment could be done on the same day as long as it was requested within twenty-four hours or forty-eight hours or whatever the window was that we figured out.

MR. MINGUS: I can take that

back, Beth, be glad to. And, then, if you or someone wants to shoot me, though, an email of, again, the summary of the issue and I'll take that as well, but I did check, like I said, yesterday with our UM team to make sure that was accurate and it is.

So, I'll be glad to take the information back and tell them, hey, this is what's going on, here's what I'm hearing and we can go from there.

DR. ENNIS: Okay. Happy to do that.

MR. MINGUS: I appreciate that Thank you.

DR. THERIOT: This is Dr. Theriot. I think it's a great idea to kind do them both on the same day because that locks the patient in and it makes them realize how important it is and they're already there.

DR. ENNIS: Exactly, and this covers all three disciplines, but if you can do something intervention-wise that's going to help them rather than just, okay, here's what we're going to be working on in the future, you're more likely to have them come back, whether it's an adult, whether it's a kid. If they can see some of the benefit of why this

is important, you're more likely to get them to return and you're less likely to have a no-show.

So, that's why we worked through this a couple of years ago. And, so, I was kind of surprised to see this come up again.

MR. MINGUS: Well, I'll tell you what I'm going to do. I'll take the information that Dr. Theriot gave as well as you, Beth, just now and I'll put that in a summary and get it to our UM Department.

And it may be best where I try to set up something where yourself maybe reaches out to our UM contact and discuss it and do it that way.

DR. ENNIS: Sounds good. And, Dr. Theriot, I appreciate you chiming in, absolutely.

MR. MINGUS: I appreciate it.

MS. SAGASER: Beth, I just have a question, if we could ask for the justification since we're not seeing that from a PT and OT perspective, what the justification would be for speech specifically.

MS. SACCA: On that, if that was a decision made by you.

DR. ENNIS: Yeah, because we got that fixed for the other two and I thought it was

across all three. So, there's some reasoning why speech is separated out and we would love to know.

MR. MINGUS: I will definitely take that question back as well. Thank you all.

DR. ENNIS: And, Renea, did you have something else?

MS. SAGASER: Is that visit during the eval count as one of the twenty?

MR. MINGUS: I do not believe it is but I will get clarification on that.

DR. ENNIS: Thank you. We were asked to look at access issues, and I think our biggest access issue from a therapy perspective right now has to do with the parsing out of small numbers of visits at a time because it's a significant administrative burden to continue to ask for more visits and, then, it takes time to get those, and, then, again, patients will not come back.

So, I think the Utilization Management, the third-party administrator piece is kind of our biggest access issue right now but I'm going to open it to other TAC members to see what other issues they're seeing related to access.

MS. WILSON: WellCare has recently changed their authorization process and

they're requiring a plan of care now. So, we're kind of moving in the wrong direction with things getting easier and less burdensome. So, now auths are taking longer and are more cumbersome.

DR. ENNIS: The other thing I want to throw out is are we being authorized visits or codes? I want to make sure we've gotten down to the visit and not back to the code issue.

MS. WILSON: I'll have to ask but I can find out real quick.

DR. ENNIS: Dale, Renea, what are you guys seeing?

MS. SAGASER: I think it depends on the insurance company on there for visits or codes. So, I can ask for a detailed report if you use during visits versus codes and get back to you on a spreadsheet.

DR. ENNIS: That would be great.

DR. LYNN: Same here, Beth.

DR. ENNIS: Because that's the other process that we worked through several years ago that I think has reverted back with the shift in third-party administrators that all of the MCOs are using is that some of them are asking for specific code precerts which defeats the purpose because we

may not be using those specific codes, depending on how that adult/child comes in that day.

MS. SAGASER: Right. I'll ask which specific carrier, which ones are doing that. It's not everybody. Some are visits.

MS. WILSON: I think the majority are visits but I can do a list, too.

DR. ENNIS: Emily, what are you seeing on the hospital side?

MS. SACCA: I'm actually asking right now to look at the documentation between the forms that we actually fill out and (inaudible). I know I've seen mixed. I'm just trying to determine at this point whether or not it's by unit based on our wound care CPT codes versus our other therapy CPT codes but I can do the same to submit something to you.

DR. ENNIS: That would be great. Linda, what about you?

MS. DEROSSETT: I'm checking on that also but I was going to ask one question. When you all are doing the authorization, is this the initial authorization or after so many visits' authorizations?

DR. ENNIS; Both.

MS. DEROSSETT: Because what we're seeing is we send in for an authorization and they keep saying that preauthorization has been waived on our initial visits. Then after twenty visits, they're starting to deny saying we have to do it after twenty visits get the authorizations.

Then we go to get the authorization after the twenty visits and, then, they're saying we don't need authorization. So, we're going back and forth.

DR. ENNIS: Is that with a specific MCO, Linda, or is that with fee-for-service?

MS. DEROSSETT: This is for Medicaid and they said it pertained to the MCOs also.

DR. ENNIS: Okay, because I know that Medicaid, fee-for-service Medicaid was not requiring prior auth for the first twenty, and I thought at one point Passport was not either but I thought the rest of them were.

MS. DEROSSETT: That's what we're running into issues with, going back and forth with our denial management versus our preauthorization team and in talking to people and they're getting different answers. So, we're trying to go back and meet with each one of them.

So, if anybody has any ideas on any of them or if any of the MCOs are on the call that can answer that, that would be great.

MS. PARKER: This is Angie with Medicaid. Linda, are you with a hospital?

MS. DEROSSETT: Yes.

MS. PARKER: That's the issue because right now any hospital service, prior authorization is waived.

MS. SACCA: Linda, I had that same conversation with our preauth and denial groups where we are billing as Type I providers. Our authorization is submitted on that for the hospital-based clinics.

MS. DEROSSETT: Then, what after the twenty visits?

MS. PARKER: Well, if the benefit is twenty visits----

MS. DEROSSETT: I didn't catch that. I'm sorry.

MS. PARKER: If the benefit is twenty visits, then, technically, they don't have more than twenty visits, but anything over that can be looked at for medical necessity.

MS. DEROSSETT: Okay. And now

you're saying this reaches out across the MCOs, is that correct, for hospital-based?

MS. PARKER: Yes, it is and for fee-for-service.

MS. DEROSSETT: Okay. Thank you.

DR. ENNIS: And, then, just to clarify, for non-hospital-based outpatient clinics, is fee-for-service still waiving precert for the first twenty visits?

MS. GUICE: We're not waiving it. It's just not required.

DR. ENNIS: It's not required.

MS. GUICE: Yeah. The benefit is twenty visits. And, so, anything after that has to be reviewed for medical necessity.

DR. ENNIS: Okay. I'm going to run through our MCOs just to see if anybody else is doing that just so we can clarify on the non-hospital-based outpatient side. Let's go backwards just for fun and giggles. WellCare.

MR. MINGUS: What's the question again? I apologize.

DR. ENNIS: Are you guys requiring prior authorization for the twenty visits

of outpatient therapies that are under the State Plan?

MR. MINGUS: Yes, I believe we are but I will verify that.

DR. ENNIS: Okay. I'm fairly certain you are, too, but I just wanted to make sure.

MR. MINGUS: Right. I want to verify because sometimes things change but I will definitely get verification on that.

DR. ENNIS: Sure. Passport.

DR. JAMES: This is Dr. Tom James. We do not require prior authorizations for the first twenty but what my Medical Directors are looking for after that point is is there progress being made, is the person being compliant, looking for really a succinct listing of outcomes and directions of therapies rather than 128 pages like I got last week. Sorry for an editorial on that.

DR. ENNIS: I appreciate that because there are times where therapists feel like they need to send those 128 pages because when they send succinct, they're told it's not enough.

So, it's nice to know that somebody is looking for less for a focus more appropriate. So, that's good to know.

DR. JAMES: We had something out on our web page until COVID. Once we're allowed to start doing more reviews, we'd like to be able to get with you so we can have a focused process.

DR. ENNIS: Sounds perfect. Sounds great. And I skipped United. My alphabet is not working this morning. I'm sorry.

MR. CUSTER: Good morning. This is Guy with Humana. Yes, we do require the outpatient prior authorizations for twenty.

DR. ENNIS: Okay. United Healthcare.

MS. MACKLIN: Guy, I wanted to comment. This is Zelda. I'm also on from Humana from our UMT.

MR. CUSTER: Thank you, Zelda.

MS. MACKLIN: You're welcome. Actually, we do not. Since we started on the Humana side, we do not require an authorization for the first twenty visits. Of course, if they're pediatric under twenty-one, we give them unlimited, and, then, over twenty-one, we require an auth at the twenty-first visit.

MR. CUSTER: Thank you for that clarification. I thought I had read a change where

they were requiring it.

MS. MACKLIN: That might be to come when we get a vendor but, no. Since we've started, that's not been the requirement.

DR. ENNIS: Thank you. Appreciate that clarification. Should we go back to United Healthcare because I skipped them, if anyone from United is on the call. They may not be.

UNKNOWN: And to clarify, these are for non-facility based, correct?

DR. ENNIS: Correct.

MS. PARKER: If nobody is on from United, I will touch base with them and get that back for you.

DR. ENNIS: Thank you so much. And, then, I'm forgetting Anthem.

TIFFANY: Yes, ma'am. Anthem does not require precert for the initial twenty visits for PT, OT, ST for our PAR providers.

DR. ENNIS: Perfect. Thank you very much. Aetna. Do we have anyone from Aetna on the call?

MS. RISNER: This is Krystal Risner with Aetna. We are checking just to verify to make sure, but, yes, we do require authorization on

those initial twenty for outpatient.

DR. ENNIS: Okay. I appreciate that. Any other access issues that my TAC members have?

I think the biggest that remains is accurately assessing network capability because we have a variety of types of folks under Medicaid and they may require different types of therapists.

And, so, I'm a physical therapist. You do not want me treating your low back injury, you do want me treating your child, but I don't know that the networks drill down that far.

And looking at network adequacy, especially because of the reimbursement challenges with Medicaid, it can't all fall on one clinic or they're not going to be able to keep their lights on, is a challenge to make sure that we have adequate access for the clients that need us.

MS. SAGASER: I agree with that. That is our concern is being competitive in the market to be able to recruit therapists because we're not a hospital or a nursing home and our reimbursement is not at the same level. So, it is a concern.

DR. ENNIS: And, then, we did have a request from a TAC member to find out what the process was to request an increase in the fee schedule, and I know that that's a huge issue.

So, I guess I would throw it out to our Cabinet friends to see what the steps are that should be taken, whether it is feasible or not.

MS. GUICE: So, as far as steps to be taken, the steps that you can take would be to submit kind of a formal recommendation to the Commissioner. Be specific about what increases you want.

Be certainly aware that Medicaid only gets the money that the Legislature appropriates and a dollar only goes so far.

So, if you were to ask for a rate increase, you might consider also asking for an appropriations increase from the Legislature.

DR. ENNIS: Thank you, Lee. I appreciate that.

MS. GUICE: And that's about the best I can tell you.

DR. ENNIS: Sure.

MS. GUICE: And what we do afterwards is we will do a fiscal impact. So, take

last year's claims and attach the new rates to it and do some sort of magic about what they expect the growth to be for, like, this year there's a number that comes from someplace - it's a number and that's why I don't know too much about it - but if the growth has been like 2%, then, that 2% gets tacked on the top.

And, then, there's a fiscal impact done and everybody, then, looks around to see if there's any money that can cover that.

DR. ENNIS: Sure. I appreciate that. That will get us started.

MS. GUICE: Okay. Great.

DR. ENNIS: I'm going to throw it out to our TAC members - any other issues that have come up since we posted this agenda?

MS. WILSON: I have an issue with no-shows, and I realize that we're not allowed to charge anything which we don't, but it's very frustrating when we hold spots for these families, particularly for evaluations and, then, they don't show up.

They don't call, they don't anything and we've lost that appointment but we have a list of kids waiting and there's no accountability

there at all and that's extremely frustrating on our end.

So, we were, like, well, could there be something where they could, like, put down a deposit and they get it back when they come or I don't know, just something that would hold them accountable.

I mean, that works on the commercial side which we don't do it at all now. We don't do it across the board because we keep it the same for everyone, but it's just, yeah, we need help with that.

DR. ENNIS: Are therapists allowed to use the no-show portal? And I guess I'm throwing this out to Dr. Theriot or to Lee.

MS. GUICE: Yes. Anybody who has KYHealth.Net access. Yes, you have access to the portal. You have access to the no-show.

MS. WILSON: Yeah, and we do that. We report that as much as we can, but again, this is an administrative burden. That takes time to go in. We see hundreds of kids a week. So, it's just we're doing as best we can to report it.

DR. ENNIS: I think the other challenge is with the population that Kresta is

talking about, you can't book a child every fifteen minutes, right? This is forty-five minutes to an hour that's blocked off for this child, and if they don't show, there's nobody to put in their place.

So, it is a significant issue for therapies, especially on the pediatric side.

MS. GUICE: I'm sorry about that but there's nothing we can offer you to charge a Medicaid patient for a Medicaid anything.

You can't charge a Medicaid patient even a deposit. You can't require a credit card be put on a file because the whole point of the program is that you're serving the financially and medically vulnerable population.

MS. SAGASER: You're not charging them if they show up. You're holding them accountable.

DR. ENNIS: But she's saying you're not allowed to charge them.

MS. SAGASER: No. I know. I agree with Kresta. It's ridiculous.

MR. JACOB HATFIELD: And what happens to that information if providers report those no-shows and cancellations?

MS. GUICE: Reports are run and

reports are received by the MCOs. And for the traditional Medicaid, I think somebody in Waiver takes a look at those. You could ask the MCOs what they do with those reports.

DR. ENNIS: Does any of that information go back to the primary care provider, the person who referred them to that service in the first place?

DR. JAMES: This is Dr. Tom James with Passport. When we receive those lists, we look at the pattern. A single missed visit is one thing, but people who have several missed visits, we have an outreach that goes to the primary care physician and trying to get our case managers to get in touch with the person directly.

DR. ENNIS: I mean, it's going to circle into an access issue simply because, especially on the pediatric side. People can't block hours of time if folks aren't going to show for limited income. So, that's going to be a problem down the line if we can't figure something out with this. And I understand the not being able to charge them completely but we've got to figure something out.

DR. THERIOT: This is Dr.

Theriot again. Other than having them on the books, having the appointment set, are you guys able to send text reminders, phone calls reminding people of the appointments, anything like that?

MS. SAGASER: Yes. I mean, we go so far as our therapist gives them a call twenty-four hours before the appointment, introduces them, asks some medical questions, medical history questions and, then, we also send them a text reminder. They get several text reminders.

MS. WILSON: We do the same. And sometimes, like, we had one, I think, just yesterday that confirmed less than twenty-four hours that they were going to come and they didn't show up.

We're going above and beyond to get them in the door. I mean, it's - I don't know what else do to other than to go to their house and pick them up.

We have a doctor's office here that even provides transportation to their patients if they need it. Like, they will find a way to get them here to this building if they need help, and we're really close to a city bus stop as well.

So, if they can get on a city bus, then, they can get here.

DR. ENNIS: I don't think this is one we're going to solve on this call but we're going to hang on to it. Other issues?

MR. LYNN: Is WellCare still requiring to resubmit the claims from the beginning of last year to get the corrected rate?

MR. MINGUS: That's correct, to submit correct new claims, please, yes.

MR. LYNN: That's a pretty rough burden.

DR. ENNIS: It's a lot, yes. Other issues?

Any of our community members have an issue that we haven't touched on yet? Hearing crickets.

I'm going to send information to Lee. Do you still need some from me or is the information from this call okay on the AAC code?

MS. GUICE: If you could send something, that would be great.

DR. ENNIS: I can do that.

MS. GUICE: You speak the language and I just speak some pigeon form of that.

DR. ENNIS: We speak some language. I don't know what language it is but there

it is. We'll send information to WellCare on the eval and treat for speech and why that's different from PT/OT and see if we can get that fixed.

I believe we meet again in May. And in the meantime, please send any issues that you guys have and we can try to work on them in between or bring them to the next meeting.

I apologize again for being late.

MR. CUSTER: Beth, this is Guy. I just wanted to ask. Did you need an update on the therapy rate project for Humana?

DR. ENNIS: Yes, please.

MR. CUSTER: That was completed. Actually, I think they went back in and closed it because it shows January 12th completed. There were a little over 31,000 claims reprocessed.

DR. ENNIS: So, they did finish that. That's great. I appreciate that.

While we're on that topic, I apologize. I'll pull in the others. The other MCOs, has anyone else finished reprocessing last year's incorrect claims?

MS. ROPER: This is Krystal with Passport. Yes, ours completed on February 23rd. We

processed over about 75,000 claims. There were under 100 that were not reprocessed; but once that goes through our check processing, they're going to get those reviewed and get those completed, too, and that should be done by the end of next week.

DR. ENNIS: Terrific. Thank you. Anthem.

MS. OWENS: I am not sure for our Claims Department. We'll have to check and see and I'll get back to you.

DR. ENNIS: I appreciate that. Aetna, I know you were looking at some different things. Do you know where your process sits right now?

MS. RISNER: As of right now, I do not. I'll have to go back and touch base with that team.

DR. ENNIS: I appreciate it, and I don't think we have anyone from United on, correct?

MS. PARKER: This is Angie and I sent them an email to follow up regarding the prior auth question. So, I will get that to you hopefully today, Beth.

DR. ENNIS: Terrific. Thank you so much.

I appreciate everybody's time. I apologize again for being late and I will talk to everyone soon but see you in May.

MEETING ADJOURNED

Therapy TAC Agenda

March 1, 2022

8:30 meeting on zoom

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