



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

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April 25, 2014

TO: Medicaid Advisory Committee (MAC) Board Chairwoman Partin and MAC Board Members

RE: Response to Nursing Technical Advisory Committee (TAC) Testimony Presented at the March 28, 2014 MAC Meeting

Dear Chairwoman Partin and MAC:

We are writing to address testimony presented by the Nursing TAC at the MAC meeting on March 28, 2014. We applaud the Nursing TAC for providing their recommendations in an organized manner and encourage all other TACs to follow a similar format. The Nursing TAC first summarized their concerns and then created a numbered list of recommendations for the Department for Medicaid Services (DMS) to consider and fully respond.

- 1) Recommendation that all Managed Care Organizations (MCOs) be required to list participating APRNs.

Only unique providers who are not associated with a practice as extenders of that practice are listed as separate providers on each MCO website. If a provider is a unique provider and cannot locate their name in an MCO provider directory, they may contact Jill Hunter, Director of the Division for Provider and Member Services at Jill.Hunter2@ky.gov or 502.564.2574.

- 2) Recommendation that providers, and others who are not enrolled in a particular plan, have access to view the list of participating providers.

Each MCO posts their provider networks publicly on their website. If there is an issue with the visibility of any MCOs provider network, please contact Jill Hunter,

Director of the Division for Provider and Member Services at Jill.Hunter2@ky.gov or 502.564.2574.

- 3) Recommendation that any Medicaid MCO, and their affiliated organizations, remove requirements that a physician who has signed a prescribing agreement with an APRN must participate in the same plan as the APRN.

DMS will not interfere with the ability of the MCOs to require that their entire health care system have a contractual relationship with them to be able to provide services.

- 4) Recommendation that people be permitted to choose their PCP and that provider assignments be appropriate.

When individuals are determined eligible for Medicaid, we encourage them to select a Managed Care Organization (MCO) of their choice. If they do not choose an MCO, one is assigned to them. If a member later learns that their PCP is not in the provider network of that MCO, they have ninety days to change to a different MCO with which their PCP does contract. Members have an opportunity to select a PCP with their MCO. If they do not select a PCP, one is assigned to them per DMS guidance and provisions in the MCO contracts. Members may change their PCP if they choose by going to their MCO's website or by calling their MCO's member services phone number. WellCare, CoventryCares, Humana and Anthem allow members to see in-network PCPs who may not be the member's assigned PCP. (See Appendix A).

If you can provide a list of specific members who have been experiencing this problem, please send it to Jill Hunter, Director of the Division for Provider and Member Services at Jill.Hunter2@ky.gov or contact her at 502.564.2574 and she will look into the issue.

- 5) Recommendation that uniformity be developed for pre-authorization procedures and forms.

We are currently conducting an audit of all prior authorizations and will provide the results of that audit to the MAC when it is complete. However, MCOs must have the flexibility to design programs around the needs of their populations and prior authorizations provide them with the ability to do so. Among all services that require a prior authorization by any MCO, 90% are common to all MCOs. The vast majority of services that require a prior authorization from one MCO require a prior authorization from all MCOs.

- 6) Recommendation that requests for quality measures be narrowed down so that a whole year of full encounters and lab work do not need to be printed and faxed or mailed.

These requests are necessary for MCOs striving for accreditation through the National Committee for Quality Assurance (NCQA). We will consider this recommendation in future contracts with the MCOs, but the first few years of data

collection are particularly important in understanding the unique difference between fee-for-service and managed care and measuring quality outcomes.

- 7) Recommendation that a method for coding the various physical exams and providing appropriate reimbursement when more than one exam is required in a year, should be developed and implemented.

Under 907 KAR 3:005 Coverage of Physician's Services Section 3(1), a service must be medically necessary and clinically appropriate pursuant to the criteria established in 907 KAR 3:130. "Clinically appropriate" means appropriate pursuant to the nationally-recognized clinical criteria known such as Interqual, or nationally recognized criteria. Currently, coverage is provided for all Medicaid members for an annual preventative exam using appropriate age-defined preventative codes. Most of the elements of other types of routinely requested evaluations are captured in this annual history and examination. There are other exams that are routinely requested as well such as sports (pre-participation) physicals, camp physicals, travel, and many "others". DMS has held the position that most of the elements that may be needed to complete one of these physicals may be included in a periodic evaluation as part of the clinical record and could be utilized to complete the sports physical. However, a sports physical is not directly a covered benefit.

Coverage for an annual physical is provided through the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program. Per CMS guidelines, child health screenings are required to be provided according to a State's screening periodicity schedule. (See Appendix B). Kentucky's periodicity schedule can be found in the manual incorporated by reference into the EPSDT regulation at 907 KAR 11:035, the EPSDT Screening Services and EPSDT Special Services Policies and Procedures (May 1998). CPT codes 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99431, 99432 or 99201-99205 and 99211-99215 in conjunction with codes V20-V20.2 and/or V70.0 and/or V70.3-70.9 are used to document the receipt of an initial or periodic screen and are defined as a complete screening that is provided to bring a child up-to-date with the State's screening periodicity schedule. Sports (and "other") physicals do not include all services that are necessary to bring a child up-to-date with Kentucky's screening periodicity schedule and therefore may not be coded as an EPSDT screening to receive reimbursement.

DMS is especially concerned because we understand that some providers may be using creative coding to receive reimbursement for services, which can have a negative impact on the health of children in Kentucky. DMS is required to report all EPSDT screenings to CMS. If a provider is billing a sports physical under one of the CPT codes as listed above, this will impact the data we report to CMS and will have a negative effect on children. CMS will view these children as having received a comprehensive EPSDT physical exam and none of the outreach to ensure they receive these exams will occur, thus some children may not receive the physical exams necessary for screening and early diagnosis of health conditions.

It had been brought to our attention at the January 23, 2014 MAC meeting that “it’s all over the place on what people are coding for [physicals].” (Appendix C at p. 68) DMS would like to remind providers that under Section 2 of KRS 205.8463 Fraudulent acts – Penalties,

“[n]o person shall intentionally, knowingly, or wantonly make, present, or cause to be made or presented to an employee or officer of the Cabinet for Health and Family Services any false, fictitious, or fraudulent statement, representation, or entry in any application, claim, report, or document used in determining rights to any benefit or payment.”

Providers should be also be reminded that pursuant to 907 KAR 1:671(1)(40), an “unacceptable practice” is “conduct by a provider which constitutes ‘fraud’ or ‘provider abuse’ as defined in KRS 205.8451(2) or (8) or willful misrepresentation, and includes the following practices:

(a) Knowingly submitting, or causing the submission of false claims, or inducing, or seeking to induce, a person to submit false claims;

(b) Knowingly making, or causing to be made, or inducing, or seeking to induce, a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment, or for use in determining the right to payment;

(c) Having knowledge of an event that affects the right of a provider to receive payment and concealing or failing to disclose the event or other material omission with the intention that a payment be made or the payment is made in a greater amount than otherwise owed;

(f) Failing to maintain or to make available, for purposes of audit or investigation, administrative and medical records necessary to fully disclose the medical necessity for the nature and extent of the medical care, services and supplies furnished, or to comply with other requirements established in 907 KAR 1:673, Section 2;

Pursuant to 907 KAR 1:671, if the department receives a complaint from DMS, the Cabinet, or the Office of the Attorney General; or if questionable or unacceptable practices are identified by the department, DMS is required to conduct a preliminary investigation of alleged unacceptable practices. If during a preliminary or full investigation, DMS makes an administrative determination that a provider has committed an act of unacceptable practice, DMS is required to issue a written notice of unacceptable practice to a provider, per 907 KAR 1:671. Sanctions may include termination of a provider from the Medicaid Program, liability for civil payments, restitution for overpayments, and agency costs as specified in KRS 205.8467. Additionally, under Section 6501 of the Affordable Care Act, states are required to terminate a provider from their Medicaid Program if that individual or entity has been terminated under Medicare or any other Medicaid state plan. Sincerely,

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
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