

**BEHAVIORAL TAC  
RECOMMENDATIONS TO THE MAC  
NOVEMBER 19, 2015**

**RECOMMENDATION:** We appreciate the contacts from DMS Medical Director Dr. John Langefeld, from staff in the Office of Health Policy, and from the DBHDID Medical Director Dr. Allen Brenzel with regard to the development of more specific reports from the MCOs and the dashboard referenced in DMS' letter of July 21<sup>st</sup>. With the departure of Dr. Langefeld from DMS, the TAC wants to be assured that we will have communication on these issues from all parties involved, and that a meeting to discuss the reports and dashboard will be forthcoming.

**RECOMMENDATION:** We appreciate that DMS has been working on newly-revised standardized forms, including one for Prior Authorization (PA) so that each MCO will utilize the same form. We are extremely disappointed, however, that the newly-developed PA form is only for services and not for medications. The Behavioral Health TAC strongly recommends that work be done to develop a consistent Prior Authorization form for medications and that the draft be circulated to this TAC and to any other interested TAC for feedback.

**RECOMMENDATION:** That DMS continue to participate in discussions with the Behavioral Health TAC and with the Behavioral Health Subcommittee of the KY Health Benefit Exchange (kynect) to assure that all Medicaid benefits reflect full parity for all behavioral health services.

**RECOMMENDATION:** Finally, the Behavioral Health TAC wishes to state again this recommendation made more than two years ago: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

Thank you for providing this forum to bring forward behavioral health concerns on behalf of Medicaid members.

## **BEHAVIORAL HEALTH TAC REPORT TO THE MAC – NOVEMBER 19, 2015**

Good morning. I am Sheila Schuster, serving as Chair for the Technical Advisory Committee on Behavioral Health (BH). Our TAC had its most recent meeting at the Capitol Annex on October 29, 2015. All five (5) of the Medicaid MCOs and their Behavioral Health representatives were in attendance. In addition to the MCO representatives and four of our six TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition and others interested in the topics being presented. We also had several representatives from the KY Department for Behavioral Health, Developmental & Intellectual Disabilities, as well as from the KY Department for Medicaid Services.

We reviewed the discussion at the MAC meeting held on September 24, 2015 and the revised Behavioral Health TAC recommendations. The responses from DMS to the Behavioral Health TAC recommendations from the July, 2015 meeting of the MAC were disseminated and discussed.

In the invitation to the MCOs to attend the October TAC meeting, we noted that we would like to use the TAC meeting to have each MCO respond to these issues:

- ✓ How would someone with a primary mental health diagnosis access Occupational Therapy (OT) services? The issue has come up in terms of individuals needing help with activities of daily living.
- ✓ What is the mechanism for billing services (such as case management) for dual eligible individuals, when Medicare does not cover the service? Is an EOB required?
- ✓ Do you use child psychiatrists to do reviews of behavioral health services for children under the age of 12?
- ✓ What is the current status of your PIP regarding the use of psychotropic medications with children? Do you have any data that you can share with us?

We were very pleased to have Ms. Lee Guice from DMS at our TAC meeting to give us the background on the Medicaid Disenrollment Due to Bad Addresses initiative. There were many questions asked by those present to get as much information as possible back to Medicaid members, family members, providers and advocates about the ways in which addresses could be updated, the timeframe for the warning period and disenrollment, and the mechanism for getting the Medicaid-eligible individual re-enrolled, if dis-enrolled. The role of the MCOs in this process was also discussed. The TAC members expressed their appreciation to Ms. Guice for providing this information, while continuing to express concern about the possible negative impact of this program on individuals with behavioral health issues.

The meeting of the Behavioral Health Subcommittee of the KY Health Benefit Exchange to discuss parity of behavioral health services in Medicaid and in Qualified Health Plans had to be rescheduled for a later date. A brief survey has been circulated among consumers, family members, providers and advocates and the feedback received will be shared at that meeting, where representatives of kynect, DMS, DBHDID and the Department of Insurance as well as all of the plans will be present. Information from that discussion will be shared with the TAC at our next meeting.

With discussion, the TAC gained some clarity around the provision of services like Occupational Therapy (OT) to individuals with a behavioral health diagnosis. We also had the opportunity to resolve an issue brought to the TAC by a child psychiatrist over repeated PA requests for the same medication prescribed for the same patient. Each of the MCOs indicated that they use a child psychiatrist to review denials of services or medications requested by a child psychiatrist, although Coventry/Aetna/MH Net requires that the request for a child psychiatrist reviewer be specifically made by the provider. The MCOs described the status of their PIPs on psychotropic medications with children; most are in the data-gathering/establishing-baseline phase. Finally – as always – we held a discussion about integrated care and its importance and the difficulties in assessing whether it is happening or not! The MCOs are required under their new contracts to address integrated care as PIP in 2016 and we are hopeful that we will be able to see documentation of outcomes in this area.

The next meeting of the Behavioral Health TAC will be held on Thursday, January 7, 2016 at 2:15 p.m. in Room 125 of the Capitol Annex.

**NOVEMBER 19, 2015 RECOMMENDATIONS TO THE MAC:**

**RECOMMENDATION:** We appreciate the contacts from DMS Medical Director Dr. John Langefeld, from staff in the Office of Health Policy, and from the DBHDID Medical Director Dr. Allen Brenzel with regard to the development of more specific reports from the MCOs and the dashboard referenced in DMS' letter of July 21<sup>st</sup>. With the departure of Dr. Langefeld from DMS, the TAC wants to be assured that we will have communication on these issues from all parties involved, and that a meeting to discuss the reports and dashboard will be forthcoming.

**RECOMMENDATION:** We appreciate that DMS has been working on newly-revised standardized forms, including one for Prior Authorization (PA) so that each MCO will utilize the same form. We are extremely disappointed, however, that the newly-developed PA form is only for services and not for medications. The Behavioral Health TAC strongly recommends that work be done to develop a consistent Prior Authorization form for medications and that the draft be circulated to this TAC and to any other interested TAC for feedback.

**RECOMMENDATION:** That DMS continue to participate in discussions with the Behavioral Health TAC and with the Behavioral Health Subcommittee of the KY Health Benefit Exchange (kynect) to assure that all Medicaid benefits reflect full parity for all behavioral health services.

**RECOMMENDATION:** Finally, the Behavioral Health TAC wishes to state again this recommendation made more than two years ago: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

Thank you for providing this forum to bring forward behavioral health concerns on behalf of Medicaid members.



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

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

October 27, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Behavioral Health Technical Advisory Committee (TAC)  
Recommendations Presented at the September 24, 2015, MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Behavioral Health TAC recommendations presented at the September 24, 2015, MAC meeting.

1. **Recommendation 201509BH01:** We appreciate the communication from DMS to the Behavioral Health TAC that various DMS divisions and staff are engaged in the development of the dashboard referenced in DMS' letter of July 21st in response to our previous recommendation. Dr. John Langefeld, DMS Medical Director, has been identified as the point of comment and we recommend that Dr. Langefeld contact Dr. Schuster as the TAC representative to begin a dialogue on this important issue.

**Response:** Dr. Langefeld is working with Dr. Schuster: DMS will continue to provide updates on the development of the dashboard.

2. **Recommendation 201509BH02:** We appreciate that DMS has been working on newly-revised standardized forms, including one for Prior Authorization (PA) so that each MCO will utilize the same form. We are extremely disappointed, however, that the newly-developed PA form is only for services and not for medications. The Behavioral Health TAC strongly recommends that work be done to develop a consistent Prior Authorization form for medications and that the draft be circulated to this TAC and to any other interested TAC for feedback.

**Response:** The standardized prior authorization form was not developed to include pharmacy due to the different formularies that each MCO utilizes in order to manage the care of their members.

- Recommendation 201509BH03:** The behavioral health TAC is assuming that when DMS receives information from the MCOs each month/quarter/semi-annually that DMS staff is doing some review and analysis of that data to see whether it falls within acceptable standards or not. We also assume that these standards allow DMS to decide if a particular MCO is an outlier or is outside of the norm as reflected in the data they are submitting. It is our understanding that the MCOs must report on a regular basis the denials and readmissions of members to psychiatric hospitals and crisis stabilization units. Thus we ask that DMS share with us the criteria or “industry standard” it is using in assessing data submitted from the MCOs with regard to: denials and readmissions to Psychiatric Hospitals and Crisis Stabilization.

**Response:** The MCO contractual reports are reviewed, when submitted, by MCO Oversight staff as well as nursing staff in the Division of Program Quality & Outcomes. In addition, they are reviewed by staff in DBHDID and discussed during regular meetings with MCOs to identify trends and/or problems reflected in the reports.

- Recommendation 201509BH04:** That DMS continue to participate in discussions with the Behavioral Health TAC and with the Behavioral Health Subcommittee of the KY Health Benefit Exchange (kynect) to assure that all Medicaid benefits reflect full parity for all behavioral health services.

**Response:** DMS will continue to participate in discussions with the Behavioral Health Technical Advisory Committee and with the Behavioral Health Subcommittee of the KY Health Benefit Exchange.

Sincerely,

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Cindy Arflack, Director, Division of Program Quality and Outcomes  
Lee Guice, Director, Division of Policy and Operations  
Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Carrie Cotton, Senior Policy Advisor, Department for Medicaid Services

## **Children's Health Technical Advisory Committee**

Presented on November 19, 2015

Hello, my name is Stephen Lin and I am the designee to the chair for the Technical Advisory Committee for Children's Health. Our TAC met on November 4<sup>th</sup> with DMS staff, MCO representatives, and most of the members in attendance.

A couple of weeks ago, the TAC discussed the mismatched address policy implemented by DMS. The members of the TAC were concerned that children would not receive the care or medication they need at no fault of their own. An address for a child would need to be changed by an adult, parent, or guardian and would be subject to this process and could possibly miss an appointment or not receive medication.

We also discussed children's oral health issues with MCO representatives and DMS. We learned about gaps in preventive care for children and the implications for DMS and providers to improve preventive services to reduce future treatments for chronic issues.

Based on these discussions, the TAC has two recommendations today.

### **Recommendations:**

1. We are concerned that children in Kentucky will suffer at no fault of their own as a result of the mismatched address disenrollment process. The Children's Health TAC recommends that DMS and MCOs extend the warning period for children with a mismatched address to 6 months before disenrollment to allow parents and/or guardians time to comply with the new policy and ensure their children receive continued access to necessary health care and medication.
2. Based on data from CMS 416 and data provided by DMS and MCOs, the Children's Health TAC found that there was a serious deficiency of preventive oral health care for children under the age of 3. To increase preventive services for this age group, with the intent of decreasing future treatment services, the TAC recommends that code D0145 be made reimbursable by Medicaid (twice per year) for the following medical professional groups: dentists, dental hygienists, pediatricians, primary care physicians, physician assistants, APRNs, nurse practitioners, and RNs.



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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

October 27, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Home Health Technical Advisory Committee (TAC) Recommendations  
Presented at the July 23, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Home Health TAC recommendations presented at the September 24, 2015 MAC meeting.

1. **Recommendation:** DAIL give written instructions on how conflict free case management and independent assessment will work for patients under a hospice benefit who need to access attendant care.

**Response:** The Department for Medicaid Services is currently seeking clarification regarding individuals who are accessing Hospice Benefits through the State Plan and attendant care services through the Home and Community Based Waiver (HCBW) as it relates to conflict-free case management. In some situations the client accesses HCBW attendant care services through the consumer-directed option (CDO) utilizing a support broker and financial manager; in these instances there is no conflict. Clarification is being obtained for clients who receive the attendant care services through a traditional provider.

2. **Recommendation:** Prompt pay issue relating to clean claims for nutritional supplements for a dual eligible patient and the continuing failure of the MCOs to reimburse for those claims after repeated submission.

**Response:** Department received specific information and will be following up with Ms. Branham upon completion of review. In addition, please see the attached Department of Insurance report for the month September 2015 which summarizes the Medicaid prompt pay violations of each MCO.

3. **Recommendation:** Poll MCO's on medical necessity related to new guidelines MGC & InterQual for homebound status of Medicaid recipients.

**Response:** The Department contacted the MCOs on October 12<sup>th</sup> and 13<sup>th</sup> via email and asked them to comment. You will find the replies of the four responding Organizations attached to this document.

Sincerely,

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
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Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Carrie Cotton, Senior Policy Advisor, Department for Medicaid Services

**MEDICAID PROMPT PAYMENT COMPLIANCE (MPPC) REPORT FOR THE MONTH OF SEPTEMBER 2015**

Month of SEPTEMBER 2015										FISCAL YEAR ENDING JUNE 30, 2016						
Opened this Month	Month Disputed Lines	Month Closed	Month Closed Disputed Lines	Month Recovery	Month Interest	Month Total Recovery & Interest	YTD Opened	YTD Disputed Lines	YTD Closed	YTD Closed Disputed Lines	YTD Recovery	YTD Interest	YTD Total Recovery & Interest			
4	2	18	100	3,701.80	127.49	\$3,829.29	5	14	35	105	19,149.57	959.74	\$20,109.31			
CoventryCares	18	27	31	0.00	0	\$0.00	23	58	154	633	26,038.14	942.51	\$26,980.65			
Humana																
CareSource	29	203	9	40	1,417.17	\$1,417.17	33	110	27	131	6,801.30	343.81	\$7,145.11			
Kentucky Spirit	0	0	10	27	0.00	\$0.00	0	0	17	53	0.00	0.00	\$0.00			
Passport	3	37	1	1	0.00	\$0.00	3	37	23	62	50.51	0.90	\$51.41			
WellCare	11	38	16	78	22,840.41	\$22,922.25	16	38	90	573	101,826.29	1,159.25	\$102,985.54			
<b>TOTALS</b>	<b>65</b>	<b>307</b>	<b>85</b>	<b>353</b>	<b>27,959.38</b>	<b>\$28,168.71</b>	<b>80</b>	<b>257</b>	<b>346</b>	<b>1,557</b>	<b>153,865.81</b>	<b>3,406.21</b>	<b>\$157,272.02</b>			
<b>MONTH OF SEPTEMBER 2014--FOR COMPARISON PURPOSES</b>										<b>CURRENTLY OPEN FILES APRIL 15, 2013 THRU SEPTEMBER 30, 2015</b>						
Opened this Month	Month Disputed Lines	Month Closed	Month Closed Disputed Lines	Month Recovery	Month Interest	Month Total Recovery & Interest	Open	Disputed Lines	NOTES AND COMMENTS							
2	1	15	48	0.00	0.00	\$0.00	8	94								
CoventryCares	28	41	222	9,552.36	753.03	\$10,305.39	918	1,676								
Humana																
CareSource	6	15	9	55	1,606.57	25.72	35	112								
Kentucky Spirit	32	224	10	16	12,173.84	0.00	0	0								
Passport	0	0	2	1	2,550.00	0.00	4	37								
WellCare	68	582	29	116	16,236.09	192.21	29	92								
<b>TOTALS</b>	<b>136</b>	<b>863</b>	<b>287</b>	<b>721</b>	<b>42,118.86</b>	<b>970.96</b>	<b>994</b>	<b>2,011</b>								

**MEDICAID PROMPT PAYMENT COMPLIANCE (MPPC) REPORT FOR THE MONTH OF SEPTEMBER 2015**

TRANSFERRED FILES FROM DMS--CLOSED SINCE APRIL 15, 2013						MPPC APRIL 15, 2013 THRU SEPTEMBER 30, 2015						
	Closed	Closed Disputed Lines	Referred to A/R Project	Recovery	Interest	Total Recovery & Interest	Closed	Closed Disputed Lines	Recovery	Interest	Total Recovery & Interest	TOTAL RECOVERY & INTEREST-- TRANSFERRED FILES & MPPC
Anthem Medicaid	0	0	0	0.00	0.00	\$0.00	119	355	90,788.07	4,825.41	\$95,613.48	\$95,613.48
Coventry/Cares	86	8,688	3	173,728.67	4,637.54	\$178,366.21	1,613	7,890	711,855.02	40,639.97	\$752,494.99	\$930,861.20
Humana												
CareSource	1	1	0	59.49	0.00	\$59.49	118	1,651	811,863.86	11,450.35	\$823,314.21	\$823,373.70
Kentucky Spirit	58	7,425	7	80,272.58	26,558.94	\$106,831.52	1,628	8,352	486,164.34	32,063.40	\$518,227.74	\$625,059.26
Passport	5	33	0	1,400.00	0.00	\$1,400.00	67	379	39,969.38	154.46	\$40,123.84	\$41,523.84
WellCare	31	7,030	0	30,320.78	536.03	\$30,856.81	1,223	7,042	1,210,332.20	40,249.65	\$1,250,581.85	\$1,281,438.66
Other/Unknown	7	91	0	0.00	0.00	\$0.00						
<b>TOTALS</b>	<b>188</b>	<b>23,268</b>	<b>10</b>	<b>285,781.52</b>	<b>31,732.51</b>	<b>\$317,514.03</b>	<b>4,768</b>	<b>25,669</b>	<b>3,350,972.87</b>	<b>129,383.24</b>	<b>\$3,480,356.11</b>	<b>\$3,797,870.14</b>

**NOTES AND COMMENTS**

Month recovery is based on paid date. The TRANSFERRED FILES FROM DMS--CLOSED SINCE APRIL 15, 2013 identify the files which were transferred from DMS to DOI on April 15, 2013. MPPC continued to work these files until they were closed and the numbers represent the results. The MPPC APRIL 15, 2013 THRU SEPTEMBER 30, 2015 identify the results of files which were opened and have been closed by MPPC since April 15, 2013 thru the current month reporting. The TOTAL RECOVERY & INTEREST--TRANSFERRED FILES & MPPC identify the total in claims recovered including interest of both the transferred in files and the complaints opened after April 15, 2013.

**MCO responses to the Home Health TAC Recommendation presented  
at the September 24, 2015 MAC meeting**

**CoventryCares soon to be known as AENTA**

**InterQual Homebound status definition under Home Care Services**

- **Adult**
  - Normal inability to leave the home,  $\geq$  One:
    - Requires the use of an assistive device (eg, crutches, cane, walker, or wheelchair) View Notes
    - Requires special transportation (eg, ambulance or chair car)
    - Requires the assistance of another person, due to 1 of following:
      - Blind, Dementia or mental illness, Jeopardizes safety through actions, Upper extremity impairment
      - Medical contraindication to leaving the home,  $\geq$  One: Physician ordered activity restriction or Immunocompromised or Communicable disease and public health risk
      - Requiring a considerable and taxing effort to leave the home,  $\geq$  One:
        - Requiring significant assistance of another person
        - Medical contraindication to leaving the home
        - Requiring high energy demand
  - NOTES
    - A patient is not required to be bedridden to be considered homebound. Absences from home for medical treatment such as dialysis, chemotherapy, radiation therapy, or participation in an adult day care program do not exclude the patient from homebound status. Relatively short or infrequent absences from home (i.e., religious services, family reunions, hairdressing appointments) do not disqualify the patient from homebound status. Persons of advanced age that do not leave home due to insecurity are not considered homebound.
- **Pediatrics**
  - Normal inability to leave the home,  $\geq$  One:
    - Requires the use of an assistive device (eg, crutches, cane, walker, or wheelchair) View Notes
    - Requires special transportation (eg, ambulance or chair car)
    - Requires the assistance of another person, due to 1 of following:
      - Blind, mental illness, Jeopardizes safety through actions, Upper extremity impairment (Patients with upper extremity impairments may require assistance of another person to leave the home due a

number of factors including an inability to use hand rails, open doors, or maneuver their wheelchair.)

- Medical contraindication to leaving the home, at least one: Physician ordered activity restriction or Immunocompromised or Communicable disease and public health risk
- Requiring a considerable and taxing effort to leave the home,  $\geq$  One:
  - Requiring significant assistance (Patients may require moderate to maximum or complete assist due to: Unsteady gait, poor ambulation, or history of frequent falls, Paralysis or paresis, Significant to severe weakness, Impaired mobility due to recent fracture, surgery, or arthritis, Patient is bedbound or chair bound, Ventilator dependent)
  - Requiring high energy demand (The amount of energy required for a patient to enter in and out of the home, vehicle, or clinic may require a high amount of work energy (i.e., the patient is unable to ambulate 20 feet without dyspnea, requires frequent rest periods due to pain, etc.). This energy expenditure may leave the patient with insufficient strength to make the outpatient treatment as effective as it would be if the patient were to receive the treatment in their home.)

## PASSPORT

According to InterQual 2015 criteria for Skilled Nursing:

*The criteria are appropriate for adults requiring intermittent home care services. Delivery of skilled services in the home requires the following:*

- *Patient clinically stable (no anticipated worsening in severity)*
- *Medical practitioner orders or approved plan of care at least every 60 days*
- *Reasonable expectation for clinical or functional improvement or prevention of further decline*
- *PO fluid tolerated or nutritional route established (e.g., IV, enteral feeding tube)*
- *Home care agency can safely deliver the required care at home*
- *Home environment is safe, accessible, and can be modified to accommodate the home care plan*

InterQual 2015's Home Care Criteria has been transformed into a question and answer format, which is supposed to assist UM to conduct reviews faster. Home bound status is a question addressed in IQ but answering *no; not homebound* does **not** disqualify the member for home services.

Home bound status in IQ follows Medicare definition of home bound:

*According to the definition in IQ for homebound: "A patient is not required to be bed ridden to be considered home bound. Absences from home for medical treatment such as dialysis, chemotherapy or participation in adult day care do not exclude the patient from home bound*

*status. Relatively short or infrequent absences from the home (i.e. religious services, family reunion) do not disqualify the patient from home bound status. Persons of advanced age who do not leave the home due to insecurity are not considered homebound. Centers for Medicare and Medicare – Medicare Benefit Policy Manual 2014.”*

Passport Utilization Management does not make home bound status a requirement for a member to receive home health services, nor does Passport disqualify a member if the member does not completely meet the definition of home bound. All aspects of the member are considered including medical necessity of the requested service, as well as other factors that may prevent the member from obtaining service elsewhere (i.e. transportation, medical condition, lack of caregiver support). A home health request is never denied simply on the basis of home bound status.

### **ANTHEM**

At this time we are using Milliman, per our contract. We have been having internal discussions to begin drafting a formal policy and procedure for any procedures not covered by Milliman or Interqual. We are considering also using Interqual as back up for any services not in Milliman. Should a service not be included in either criteria, we will refer to a nationally recognized criteria not created by any Anthem, Inc. companies. At this time we are considering NDC and LDC.

### **HUMANA**

BH: Beacon is using Interqual and/or a combination of the tools listed below as per the new contract:

- Level of Care Utilization System (LOCUS);
- for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS);
- for young children; Early Childhood Service Intensity Instrument (ECSII);
- for substance use: American Society of Addiction Medicine (ASAM).

Medical: We have begun using MCG where available. We refer to the KAR where there is no MCG criterion. We have requested the phone call with the state to discuss areas where we believe there are gaps.



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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

October 27, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Optometric Technical Advisory Committee (TAC) Recommendations  
Presented at the September 24, 2015, MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Optometric TAC recommendations presented at the September 24, 2015, MAC meeting.

1. **Recommendation 201509OPT01:** An amendment to add optometrists to the list of provider on the proposed regulation on Acquired Brain Injury was discussed. There are doctors of optometry who specialize in working with stroke and head injury victims. The TAC emphasized that all providers of eye/vision care be treated the same by all MCOs. ODs and MDs should submit claims to the same place and be credentialed the same.

**Response:** There are doctors of optometry who specialize in working with stroke and head injury victims. These "Behavioral Optometrists" are further trained to perform vision retraining and rehabilitation with children and adults who suffer from brain injury, stroke and other vision related problems. DMS has covered and reimbursed these services through the vision program for some years now. Waiver members have access to state plan covered services thus adding them to the waiver(s) would be duplicate coverage.

The Department reached out to the five MCO groups on October 13<sup>th</sup>, via email to give each an opportunity to respond to the credentialing and claims submission recommendation; please see the attached responses of Anthem and CoventryCares.

Sincerely,

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
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Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral  
Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Carrie Cotton, Senior Policy Advisor, Department for Medicaid Services

# **Pharmacy Technical Advisory Committee (PTAC) Recommendations to the MAC and Meeting Notes Thursday, November 12, 2015**

Kentucky Pharmacists Association, 1228 U.S. 127 South, Frankfort, KY 40601

The Meeting of the Pharmacy Technical Advisory Committee (PTAC) was called to order Thursday, November 12, 2015 at 9:30 a.m. by Chair Jeff Arnold. Those present for the meeting were as follows: Jeff Arnold, Cindy Gray, Chris Betz, Robert Warford and Suzi Francis: PTAC Members; Tom Kaye representing Aetna/Coventry; Owen Neff representing Humana CareSource; Alan Daniels representing WellCare; Andrew Rudd representing Anthem; Thea Rogers representing Passport Health Plan; Trista Chapman, Samantha McKinley and Ellen Eiler representing DMS; Trish Freeman, UKCOP, Bob McFalls, KPhA Executive Director and Angela Gibson KPhA Director of Membership and Administrative Services; and, Shannon Stiglitz from KRF on behalf of KPhA.

The minutes and report from the September 18, 2015 meeting were reviewed by Jeff Arnold with a few technical corrections made. Chris Betz moved to approve the minutes and report as updated. Motion was seconded by Cindy Gray and carried with all PTAC members in agreement.

The PTAC discussed the responses to their recommendations from the MAC from the September MAC Meeting.

Action Items Discussion: Forming a Sub Committee Work Group for Coverage of Naloxone Kits. This work group will include:

Suzi Francis, Chair  
Trish Freeman  
Tom Kaye  
Owen Neff  
Alan Daniels  
Andrew Rudd  
Thea Rogers  
Trista Chapman  
Samantha McKinley

The PTAC Members, MCOs and DMS representatives met and discussed several Pharmacy issues in the state. Discussion was brought before the group in regards with KHIE proceedings and initiatives. The PTAC would like to request at meeting with KHIE to discuss further involvement and to move the initiatives forward.

As a follow-up to the last meeting, and based on additional information supplied by DMS (see chart below), the PTAC also discussed with the MCOs issues that they see with coverage for Vaccinations across the board. There is not a clear following of all MCOs to cover all of the PTAC recommended vaccines at this time. PTAC will work with MCO representatives to gather additional information in regard to furthering coverage for all vaccines by all of the MCOs.

KENTUCKY MEDICAID POS COVERED VACCINES LIST						
VACCINE	ANTHEM	COVENTRY	HUMANA	PASSPORT	WELLCARE	FFS
HUMAN PAPILOMAVIRUS (HPV)			X			
INFLUENZA VACCINE	X	X	X	X	X	
PNEUMOCOCCAL VACCINE			X	X		
PNEUMOVAX			X	X		
TETANUS DIPHTHERIA PERTUSSIS			X			
ZOSTAVAX			X	X		
ZOSTER VACCINE LIVE			X	X		
Rx required for all vaccines.						
Members < 19 years of age receive vaccines through the Vaccines for Children Program.						

Discussion ensued on this topic. It is a deterrent for Patients to be at the Pharmacy to get a vaccine, but then be asked to come back in 3 days due to their coverage not being adequate without a Prior Authorization. That vaccination is often times lost because the Patient does not return to the Pharmacy or go to his/her Physician for the vaccine. Having consistent vaccination coverage among all MCOs could help to deter the issue and help keep costs down to insurance providers by having the preventative measure in place. With all MCOs on the same page, this would help promoting vaccinations to all Patients.

MCOs gave brief updates. Most noted no changes at this time.

Owen reported that the CVS/Caremark PBM is getting a lot of attention. The plan is not requiring all members to transfer to CVS. This issue will be addressed and resolved as quickly as possible.

Thea reported that Passport will return to dual Medicare/Medicaid offering effective January 1<sup>st</sup>, 2016 with a new Medicare Advantage Plan offering.

The Pharmacy Technical Advisory Committee makes the following recommendation to the MAC:

1. In regards to vaccinations—PTAC would like to see a movement towards all MCOs having across the board coverage on vaccines with their Pharmacists. Vaccines are of great values to cost savings in preventative measures, and a one-time cost. Having a uniform coverage with all MCOs would greatly strengthen coverage and usage.

The meeting ran a little less than 2 hours, and the next PTAC meeting was scheduled for Friday, January 8, 2016. Unless notified differently, it will be held at the Kentucky Pharmacists Association headquarters located at 1228 U.S. 127 South, Frankfort, KY 40601. All interested parties are welcome to attend and representatives from each MCO are participating on a consistent basis.

Respectfully submitted,

Jeff Arnold, Chair, PTAC

Chris Clifton, President, Kentucky Pharmacists Association



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

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

October 27, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Pharmacy Technical Advisory Committee (TAC) Recommendations  
Presented at the September 24, 2015, MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Pharmacy TAC recommendations presented at the September 24, 2015 MAC meeting.

1. **Recommendation 201509RX01:** Recommendation in regard to Coverage of Naloxone Kits to address the Heroin Epidemic in Kentucky in compliance with SB 192: The Pharmacy TAC requests that the MAC ask the Department of Medicaid Services to identify a mechanism to get reimbursement authorized for Naloxone Kits in order to make them available to certified Pharmacists as soon as possible to assist patients concerned about their family members at risk of an opioid overdose. The Pharmacy TAC has discussed the formation of subcommittees in partnership with the MCOs to help work through any distribution issues.

**Response:** All of the Kentucky health plan partners have been working for some time now toward increased access for Naloxone kits. However, there are multiple barriers. The mechanics and operations for increased access are very complex. There are numerous other issues that must be considered, including IT systems and educational support programs. Establishment of increased access, distribution, and outcome monitoring require in-depth research and analysis. DMS suggest the formation of PTAC subcommittee workgroups in partnership with MCO and DMS to perform these tasks and to render a thoroughly vetted resolution.

- 2. Recommendation 201509RX02:** Recommendation on Medicaid Member mailings: The Pharmacy TAC requests that the MAC encourage the Department of Medicaid Services and the Cabinet for Health & Family Services to initiate a media campaign to reach as many Medicaid Members as possible about the impending dis-enrollment issue due to their having moved and/or not having a valid mailing address on file.

**Response:** DMS distributed address mismatch information to every Medicaid enrolled provider in August 2015. Also, the DMS pharmacy program initiated distribution of information to pharmacy providers through professional organizations such as KPhA and the Kentucky Board of Pharmacy. In addition to these organizations, address mismatch information has been posted on the DMS webpage as well as the FFS pharmacy webpage for both providers and members. The MCOs have been encouraged to provide website information as well. At this time, funding for a media campaign is not available, and no comparison study has been completed to determine what type of campaign would be more successful than utilizing the above notification and messaging outlets.

- 3. Recommendation 201509RX03:** Recommendation in regard to coverage of vaccines other than flu: The top three vaccines that the Pharmacy TAC would like to see addressed and added to coverage consistently throughout Medicaid are vaccines for TDAP, Zoster and Pneumonia. Another one to look at is the HPV. Many patients get the first dose with their pediatrician, but do not follow up with their healthcare provider for doses 2 and 3, which are outside of the Pediatrician's care.

**Response:** DMS pharmacy program engaged each MCO to clarify point of sale vaccine coverage and prior authorization requirements for the above mentioned vaccines. Below is a chart representing the current point of sale vaccine coverage for the selected vaccines. DMS pharmacy program will review and discuss this with the MCOs collectively at the November 2015 Pharmacy Director Workgroup meeting to determine if additional pharmacy level coverage can be provided.

KENTUCKY MEDICAID POS COVERED VACCINES LIST						
VACCINE	ANTHEM	COVENTRY	HUMANA	PASSPORT	WELLCARE	FFS
HUMAN PAPILOMAVIRUS (HPV)			X			
INFLUENZA VACCINE	X	X	X	X	X	
PNEUMOCOCCAL VACCINE			X	X		
PNEUMOVAX			X	X		
TETANUS DIPHTHERIA PERTUSSIS			X			
ZOSTAVAX			X	X		
ZOSTER VACCINE LIVE			X	X		
Rx required for all vaccines.						
Members < 19 years of age receive vaccines through the Vaccines for Children Program.						

Sincerely,

Lisa Lee, Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Cindy Arflack, Director, Division of Program Quality and Outcomes  
Lee Guice, Director, Division of Policy and Operations  
Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral  
Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Carrie Cotton, Senior Policy Analyst, Department for Medicaid Services



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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

October 27, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Physician's Technical Advisory Committee (TAC) Recommendations  
Presented at the September 24, 2015, MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Physician's TAC recommendations presented at the September 24, 2015 MAC meeting.

1. **Recommendation 201509PS01:** All covered physician and other healthcare providers should be enrolled into a Managed Care Organization within 45 days. Any missing information should be conveyed back to the physician within 5 days.

**Response:** Managed Care Organizations (MCOs) are required by the Department for Medicaid Services (Department) to approve or deny the credentialing and contracting of a provider within 90 days of receiving a correct and complete application. The Department is required to approve or deny enrollment of a provider in Medicaid within 90 days of receiving a correct and complete application. If the provider is providing substance use treatment services, the MCO and the Department are required to approve or deny the application within 45 days of receipt. Often times the necessary corrections are not discovered until the application is reviewed which may be at any point during the 90-day period. Providers are notified immediately when a correction is required. The Department recently revised the MCO reports to reflect the average processing time for an MCO to contract and credential a provider, and will use that information to enforce the contract provisions. The current average processing time for the Department to process an enrollment application is 49 business days if directly submitted and 11 days if submitted through an MCO.

- 2. Recommendation 201509PS02:** At the last Medicaid Advisory Council (MAC), Commissioner Lee indicated that DMS would begin the process of reviewing 907 KAR 3:010(4)(1) to see if it still has relevance. While this is good news we would recommend that DMS immediately review the “edit” process when CPT 99214 and 99215 exceed the limits outlined in 907 KAR 3:010(4)(1) and ensure that MCOs are in compliance with the regulation and services are not denied but reduced to the payment of CPT 99213.

**Response:** Commissioner Lee sent the following reminder via email to the MCOs on October 27, 2015:

MCO Partners,

Attached is a response to the Medicaid Advisory Committee (MAC) addressing recommendations made by the various Technical Advisory Committees (TAC). Please note the first recommendation on page 11 of the document. This recommendation relates to the limitation of evaluation and management codes 99214 and 99215 outline in 907 KAR 3:010(4)(b). This recommendation was also presented to the Department in the latest communication from the MAC.

Currently, a conflict exists between the CMS approved state plan and the state regulation as it relates to the limitations of 99214 and 99215. The approved state plan allows for two (2) visits **per member per provider** per year while the state regulation limits the number of visits to two per member per year. It is the Department’s position that the MCOs may exceed the service limitation outlined in the regulation. The Department will consider MCO paid claims in excess of the limitations spelled out in the regulation as valid encounters for rate setting purposes.

In addition, the Department has heard from several providers that some MCOs are denying claims for 99214 and 99215 that are billed in excess of the specified limit rather than paying the rate for 99213 as the Department does. Can you please verify if this is your current practice? Please feel free to respond only to me rather than replying to all on this email.

Again, I would like to stress that the Department will consider MCO paid claims in excess of the limitations spelled out in the regulation as valid encounters for rate setting purposes.

Please let me know if you have questions related to this communication.

You will find that the September 2015 MAC meeting binder and the website at <http://www.chfs.ky.gov/dms/MAC+reports+binder.htm#section8> also contain the MAC recommendation and the DMS response that is cited by Commissioner Lee in this communication.

- 3. Recommendation 201509PS03:** The TAC understands that the MCOs are not able to provide ICD-10 coding advice, we would recommend that MCOs offer some type of ICD-10 portal or immediate assistance for help specific to ICD-10. This would help with identifying, tracking and problem resolution.

**Response:** The Department maintains a webpage within the DMS website specific for ICD-10: <http://chfs.ky.gov/dms/ICD10.htm> . Here you will find information such as but not limited to – what’s new, background of ICD-10, transitioning, benefits of ICD-10, preparing for ICD-10 and KY Medicaid ICD-10 FAQs.

Additionally, CMS maintains a webpage containing information related to ICD-10: <https://www.cms.gov/Medicare/Coding/ICD10/index.html> .

The Department reached out to each MCO by email and offered them an opportunity to comment. Four of the MCOs responded with the following information concerning their efforts to educate and assist providers during this transition:

Passport Health Plan has taken several steps in providing education to their providers. In addition to an ICD-10 Implementation PowerPoint, three Provider Outreach communications have been sent starting in May 2015. Further, the Provider Relations Specialists have been discussing ICD-10 at every site visit for the past several months, as well as providing additional resources. In addition, transitioning to the ICD-10 was a topic for the nine statewide workshops that are currently being provided.

Coventry has sent out fax blast to providers and presented a detailed PowerPoint to the Physician Network Group. A letter was also sent out to providers. Coventry has the following ICD-10 informational pages listed on their website:

Coventry ICD10 FAQs August 2015

<http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty/documents/document/c147615.pdf>

Coventry’s response to CMS additional guidance July 2015

<http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty/documents/document/c147616.pdf>

Coventry ICD10 testing and metric overview

<http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty/documents/document/c147617.pdf>

Now Accepting Pre-Certifications for ICD-10

<http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty/documents/document/c142491.pdf>

Coventry FAQ's November 2014

<http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty/documents/document/c137881.pdf>

New ICD-10 Compliance Date Set

<http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty/documents/document/c123147.pdf>

HCFA 1500 Update

<http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty/documents/document/c117173.pdf>

As well as, a document library found at:

<http://chcmedicaid-kentucky.coventryhealthcare.com/for-providers/hipaa-5010-icd10/index.htm>

WellCare sent several ICD-10 flyers to providers from CMS' Medicaid Learning Network. They also sent an electronic copy the CMS Federal Register discussing that section of the Final Rule concerning ICD-10 to enrolled providers. WellCare also had open discussion at WellCare Provider Forums.

Humana provided multiple network notifications and have an ICD-10 resource center on the CareSource website. The provider reps would let the providers know that there is information on the website as well as on the CMS website if they had any questions related to the transition. Additionally, CareSource did a thumb drive project in which all of our ICD-10 resource information, network notifications and helpful CMS and coding links were placed on a thumb drive a mailed to all counties listed as rural. This was to assist providers that are not regularly on the internet to still obtain the necessary information.

Sincerely,

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
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Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Carrie Cotton, Senior Policy Advisor, Department for Medicaid Services

## Primary Care TAC Recommendation to the MAC

November 19, 2015

The Primary Care TAC met on November 5<sup>th</sup>, 2015 with a quorum present.

Respectfully the TAC submits the following comments to the MAC for consideration.

The eligibility/assignment process corrections and the recoupment of payments is going back beyond 12 months, in many circumstances. For example, one MCO is recouping on 99214s and 99215s as far back as 2011 and others are recouping on eligibility/ process corrections back to 2013.

The admitted problem between the CMS approved SPA and the regulation on the 99214 and 99215 issue requires the difference in payment under the PPS and the recouped amount be calculated and tracked manually if the recoupment was for a date of service prior to June 30, 2014. While cumbersome, because it will have to be handled manually by clinics and DMS, it does not pose the problem that eligibility/assignment recoupments over 12 months old do. At that point providers confront the timely filing issue with the MCO liable for coverage of the patient at the time of service.

We therefore request and recommend the following be forwarded to by the MAC to DMS for their response:

**In accordance with what we are advised are Medicare rules, providers should be given exemption from the 12-month timely filing to MCOs or DMS for claims involving eligibility/disenrollment or recoupments where another MCO or DMS has or may have payment liability for care provided on the date of service.**



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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

October 27, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Primary Care Technical Advisory Committee (TAC) Recommendations  
Presented at the September 24, 2015, MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Primary Care TAC recommendations presented at the September 24, 2015 MAC meeting.

1. **Recommendation 201509PC01:** DMS reports that changes are being made to the automated wrap process, but the administrative burden has not been lessened, to date. Electronic EOBs are critical in allowing clinics to use the management tools that EMRs have provided. Clinics have to add time, personnel and use scarce resources on non-medical costs to work through a process that is cumbersome and time consuming. More rapid deployment of an electronic EOB is an imperative.

**Response:** DMS has a change order in process that is looking into the possibility of adapting the EOBs to allow providers to auto post. However, there have been some issues of obtaining the pertinent information providers have stated they must have in order to process. This information is currently not transmitted to DMS on the encounters from the MCO's but we are currently looking in to the possibility of obtaining the information.

2. **Recommendation 201509PC02:** While DMS and the clinics are moving forward with the manual reconciliation of claims from 11/1/11 to 6/30/14, the automated wrap process implemented effective July 1, 2014 still has major flaws that impairs smooth operation and timely reimbursement from DMS to clinics. We have documented continued problems related specifically to crossover claims. We ask that DMS convene a workgroup of DMS, KPCA affected clinics and the MCOs (jointly or individually) to determine root cause issues and develop an understanding by all parties of what is needed and how the solution will be deployed to the benefit of all parties.

**Response:** The Department has thoroughly examined every issue brought before us and have concluded most, if not all, the issues are the result of incorrect information on the encounter data received from the MCOs. For example, crossover encounters for dual eligible members were being sent as denied encounters which excluded them from the automated wrap payment process since only paid encounters are eligible. The Department is working diligently with the MCOs to define and implement a solution which will include the MCOs submitting corrected encounters.

3. **Recommendation 201509PC03:** And finally, the TAC recommends that DMS consider adding the Transitional Care Management Codes to the Medicaid Fee Schedule as a way to arm clinics and others to affordably approach reduction of readmissions, lowering downstream costs and improving the health of our patients.

**Response:** The Department is reviewing the efficacy of adding transitional care management codes to RHC's and FQHC's for the 2016 Medicaid fee schedule for Kentucky Medicaid eligible providers. DMS will issue an updated response once the review is complete and a decision has been made.

Sincerely,

Lisa Lee, Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Cindy Arflack, Director, Division of Program Quality and Outcomes  
Lee Guice, Director, Division of Policy and Operations  
Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services  
Carrie Cotton, Senior Policy Advisor, Department for Medicaid Services

**THERAPY TAC**  
**RECOMMENDATIONS TO MAC**  
**NOVEMBER 19, 2015**

The TAC requests that the Cabinet consider creating Multi-specialty Provider Type for therapy services, so practices do not have to have up to three separate group numbers for their providers. This would be similar to the Mental Health Multi-group and could look something like below:

Therapy Multi-Specialty Group Provider Type XX

Information about the program:

- Provider must be an entity.
- Out-of-state providers may enroll.

Information to be submitted by the provider for application processing:

- Map-811(Enrollment)
- Map-811 Addendum E and verification of bank account/routing number such as voided check or bank letter if provider chooses to enroll in direct deposit
- Map-347 for all health providers within the group. (Individual provider number must be active in order to join a group.)
- IRS letter of verification of FEIN or Official IRS documentation stating FEIN.

FEIN must be pre-printed by IRS on documentation. W-9 forms will not be accepted.

- NPI and Taxonomy Code Verification

The following provider types can link to this provider type:

79 Speech Therapy

87 Physical Therapy

88 Occupational Therapy

Therapy Technical Advisory Committee Meeting

11/04/15 8:30

**MEMBERS IN ATTENDANCE:** DR. BETH ENNIS, CHAIR (PT)

**MEMBERS ATTENDING VIA CONFERENCE CALL:** LESLIE SIZEMORE (OT), LINDA GREGORY (SLP), CHARLIE WORKMAN (PT), BETHANY BERRY (SLP)

**VISITORS IN ATTENDANCE:** Pat Russell, WellCare; Peggy Hagan, Anthem; Jessica Jackson, CJ Jones, DMS

**VISITORS ON PHONE:**

Jennifer – KIDSPOT; Karen Lenz; Mary Hiett, Humana; Stephanie Bates, DMS; Lyris Childs, DMS

Chair called Meeting to order after introductions.

1. Reviewed Response from Commissioner's Office regarding MAC recommendations (sent to

-CFY - working on it - department in process of SPA submission

-Billing - visit vs unit codes. Staff will need claims to research but there may not be any as providers are reluctant to bill incorrectly as it may constitute fraud - predominantly speech codes and EPSDT services

-Therapist Assistant Differential - Dept. responded that there is no plan to make changes, any rate changes will require CMS approval

2. Old Business Discussion

a. EPSDT- chair reported providers are still able to use number and bill. Part of SPA changes - waivers will have other reimbursement rate

b. CON -Associations are looking to open Speciality Clinic regulation. In the meantime the mobile clinic regulation has been opened. Still issues regarding the requirement for Medical Director, CON is a huge expense and will reduce the number of available providers. Need to

clarify in statute "private practices of healing arts" are exempt.

c.. Billing issue with Carewise/HP - commissioner sent clarification to HP

3. Issues for November MAC -

b. Add provider type-Multidisciplinary Therapy- E-reg

4. Next Meeting - Jan 5 8:30 am



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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

October 27, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Therapy Technical Advisory Committee (TAC) Recommendations  
Presented at the September 24, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Therapy TAC recommendations presented at the September 24, 2015 MAC meeting.

1. **Recommendation 201509TS01:** Speech Therapy graduates in their CFY cannot be credentialed; therefore, cannot bill Medicaid for rendered services. Additionally, Speech Therapy grads in their CFY may not bill Medicaid under their supervising clinician's provider number, at this time. These CFY practitioners are utilized widely and not being able to bill for their services will impact access drastically. Services provided by students, interns and residents are generally billed under the supervising clinician's provider number (as long as they are credentialed). We are asking the Department to reconsider this policy.

**Response:** The Department is in the process of amending therapy services as outlined in the current SPA. This policy change is forthcoming following CMS approval and the implementation of the amendment.

2. **Recommendation 201509TS02:** HP/Carewise have been telling providers that visit based codes must be billed in a unit based manner to give them an indication of utilization. Essentially, this becomes billing fraud as CPT codes are defined as per-visit or timed. HP/Carewise have said they will change this when told to by the cabinet. We are asking that this occur.

**Response:** The Department has reiterated to HP that the appropriate indication of utilization as outlined in the current fee schedule should continue to be observed.

3. **Recommendation 201509TS03:** Therapies have been in discussion with the cabinet on the therapist/assistant differential. However, we have not had any feedback over the last two months. We are asking that this differential be removed as it is not feasible to be billed, cannot be billed in the hospital setting, and will also drastically limit access as providers will not enroll if this is in place. No other state uses this, it will not increase cost as it has not been able to be billed over the last 18 months that therapists have been providing services, and we want more providers to be able to share the burden of providing to this population.

**Response:** At this time, the Department does not plan to make any changes.

Sincerely,

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
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