

# **KENTUCKY PRIMARY CARE CENTER MEETING MINUTES**

**Cabinet for Health and Family Services  
James F. Thompson Conference Room  
275 East Main Street  
Frankfort, Kentucky**

**May 14, 2015  
10:00 a.m.**

The meeting of the Primary Care Center Technical Advisory Committee (TAC) was called to order by Chair Chris Keyser.

The TAC members in attendance: Chris Keyser, Yvonne Agan, Chris Goddard, Promod Bishnoi, Chris Goddard, Dean Shofner, Pat Bale, and Raynor Mullins. Kentucky Primary Care Association members in attendance: Joe Smith, David Bolt and Emily Beauregard.

Medicaid staff in attendance: Cindy Arflack, Teresa Cooper, Charles Douglass, David Dennis, George Hosfield, and C. J. Jones.

Others in attendance: Pat Russell, WellCare; Marie Rains and Ken Groves, Anthem; Felicia Wheeler, Humana/Caresource; Becky Murphy, Passport; Laura Malloy, CoventryCares; Darryl Wilson and Stephanie Wilson, Barbourville Family Health Center; Todd Schiavone, Blue & Co.

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A quorum was present. A motion was made by Mr. Schofner, seconded by Ms. Agan and unanimously approved to accept the March, 2014 meeting minutes.

## **OLD BUSINESS:**

**AUTOMATED WRAP PAYMENT PROCESS:** (a) Timeframe on DMS system edits: Mr. Dennis stated DMS is constantly monitoring and tweaking errors found and that payments are now being processed.

(b) Electronic EOBs for auto-posting: Mr. Dennis is working on this issue but asked for verification from the TAC concerning the claim ID number and if that ID number is the same for each one of the claims submitted to the MCOs for same date of service.

(c) Status update on dental claims: Mr. Dennis stated that he had asked Avesis to correct these claims back to 7/1/14, and Mr. Bolt confirmed that Avesis was ready to do this but he would follow up with them.

(d) Status update on clinics with wrong licensure in DMS provider enrollment: Mr. Dennis stated the only way to correct this is for the provider to void their Provider Type 31 claims and re-bill as Provider Type 35 to the MCOs. Mr. Dennis noted that eight to ten facilities have made the change and Mr. Bolt asked for a listing of those facilities. Ms. Russell stated that WellCare does not capture provider type when claims come in but that it is driven by the NPI and the taxonomy. She stated it would be an easier process if the MCOs just voided the claims that DMS identified and then resubmitted the claims, and Mr. Dennis stated DMS will work with the MCOs on this.

(e) Reports on inconsistent payments and no wrap on appealed claims: Mr. Dennis stated that DMS would need examples of this and that these examples need to be sent to him and Cindy Arflack.

(f) Automated system still has issues and problems with dual eligible claims post July 1, 2014: Mr. Dennis noted that originally these dual eligible claims were coming in as denied claims but DMS has corrected this. If facilities are still having outstanding issues, they should go directly to the MCOs. Ms. Beauregard asked about the issue of the taxonomy being stripped off, and Ms. Arflack noted that DMS is researching the examples that CoventryCares sent in and this will be reported back to the TAC in a future meeting.

(g) Clarification on process for handling recoupments post July 1, 2014 with dates of service prior to July 1, 2014: Ms. Cooper stated these would have to be included in the reconciliations because there is no way to process them systematically.

## **STATUS OF WRAP PAYMENT AND DUAL ELIGIBLE RECONCILIATION PROCESS (11/1/11-6/30/14):**

(a) When can clinics expect to receive payment on manual reconciliation and what will the process be to discuss any DMS identified discrepancies: Mr. Dennis stated that DMS will wait until June to pull down the last encounter data

from their system and then reconcile it with the spreadsheets sent in by facilities and then Myers & Stauffer should be able to process fairly quickly after that. After this process, if facilities still have claims that are not on the encounters received from the MCOs, DMS will do a sampling of the remittance advices for those claims. Mr. Dennis noted that this should satisfy CMS when doing their audit and DMS will use those claims and will give facilities credit for them.

- (b) What is happening with the Avesis, other dental, BH and DentaQuest claims from 11/1/11 to 6/30/14: Mr. Dennis noted that facilities need to put dental claims on the spreadsheets prior to 7/1/14, and after 7/1/14, Avesis is supposed to be correcting that. Mr. Bolt noted that Dr. Jerry Caudill stated that Avesis is processing and resubmitting claims from 7/1/14 to the day that they are fixed.

STATUS OF PRIMARY CARE TAC RECOMMENDATIONS APPROVED BY THE MAC: Ms. Beauregard noted that most of the recommendations have been addressed but that further into the TAC meeting, some of the recommendations will be discussed in more depth.

#### ELIGIBILITY ISSUES:

(a)Recoupments for patients based on eligibility status and retroactive enrollment: Mr. Smith stated that Medicaid is the determiner of eligibility and that if a patient shows up on the DMS portal as eligible at the time of service, that should be the ruling. Ms. Keyser stated that the issue of recoupment needs to be between the MCOs and DMS. Ms. Arflack stated that a lot of these issues have been resolved and this should not continue to be an ongoing issue. Mr. Dennis suggested that the TAC make a recommendation to the MAC concerning this issue.

(b)Eligibility discrepancy between DMS and Kynect portals: Ms. Arflack stated that this has been resolved.

ABILITY OF MCOs TO BUNDLE CODES WITH E&M, LAB AND OTHER SERVICES RECOGNIZED IN DMS FEE SCHEDULE: The TAC recommends that DMS clarify this process and make sure that all MCOs are billing accordingly and TAC members were asked to give examples to DMS.

#### OPTIONS FOR CORRECTING/UPDATING MEMBER ADDRESSES AND DEMOGRAPHIC INFORMATION:

Ms. Beauregard stated the TAC recommends that DMS create a form or work with the TAC to create a form for updating patient information, and she noted that this would be a more effective way to get corrected patient information to DMS who would then report it to the MCOs and then back to the providers.

LOCK-IN PROGRAM NOTIFICATION VIA PORTALS AND ID CARDS: Mr. Dennis stated that this issue is being handled at a higher level, and Mr. Smith asked that Ms. Beauregard prepare a letter to be sent to the appropriate DMS officials.

#### NEW BUSINESS:

FLU SHOTS AND RECOUPMENTS: Mr. Dennis stated that these will need to be handled on a case-by-case basis.

WRAP RECONCILIATION PROCESS FOR LPCCs: Mr. Dennis stated these are going to be put to the front of the line when DMS does the final reconciliation. Mr. Smith noted not all primary care centers have been notified that the data disks have to be accessed through DMS' Legal Services.

AUTOMATED WRAP CROSSOVER ISSUES: This issue was covered earlier in the meeting.

RECOMMENDATIONS TO THE MAC: Ms. Beauregard reviewed the recommendations: (1) Medicaid should be the master file for eligibility based on date of service, and if a person is eligible for services according to the DMS website, this should be the ruling; (2) DMS upgrade their system to process electronic EOBs with particular identifiers; (3) DMS create a form or work with TAC to create a form for updating patient information that both providers and the MCOs can complete on behalf of the patient; (4) DMS clarify billing for bundling issues that all MCOs could follow.

The meeting was adjourned. The next meeting date is July 9, 2015.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 8<sup>th</sup> day of June, 2015.)