

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

IN RE: DENTAL TAC
EMERGENCY MEETING

HELD VIA ZOOM

DATE:
FEBRUARY 10, 2023
2:00 P.M.

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A T T E N D E E S :

Garth Bobrowski, DMD, Chairman

Phil Schuler, DMD

Carol Braun, DMD

Joe Petrey, DMD

John Gray, DMD

(and many more were on ZOOM)

1 MS. SHEETS: Dr. Bobrowski, it looks like
2 we have three of the five. I have you and
3 Joe Petrey, John Gray. If I've missed
4 anyone, please let me know, but it does
5 look like we have a quorum.
6 DR. BOBROWSKI: Okay.
7 MS. SHEETS: And we will turn it over to
8 you.
9 DR. BOBROWSKI: We do have a quorum. And I
10 guess you have kind of officially done a
11 roll call just now. Will that suffice
12 okay, Ms. Kelli?
13 MS. SHEETS: (No response).
14 DR. BOBROWSKI: Kelli, can you hear me
15 okay?
16 MS. SHEETS: Dr. Bobrowski, we cannot hear
17 you.
18 DR. BOBROWSKI: Can you hear me now?
19 MS. LEE: I can hear you, Dr. Bobrowski.
20 Can you hear me?
21 DR. BOBROWSKI: Yeah.
22 MS. LEE: I can hear you.
23 DR. BOBROWSKI: Yeah. Okay. All right.
24 DR. SCHULER: Yeah, I hear you.
25 DR. BOBROWSKI: Okay. Well, we'll call our

1 meeting to order of the Dental TAC. And
2 this is Dr. Garth Bobrowski and I wanted to
3 welcome everyone here today. And we want
4 to -- hopefully, we have a very good and
5 interesting meeting. And I just kind of
6 wanted to kind of start us off -- and I've
7 got just a brief report that I wanted to
8 share with you-all. It's more or less as
9 an example of things we can look at doing
10 to help in a mechanism of preventive care,
11 which could mean -- well, like doing
12 fillings on teeth, help the patient, number
13 one. Number two, I think it does help to
14 minimize the cost to the state on future
15 root canals and crowns and maybe even
16 partial dentures down the road. The
17 treatment of gum disease, the same thing.
18 And I think I've mentioned this before at
19 some meetings, but just the -- you know,
20 dentistry is kind of in the -- well, I've
21 got it down here on the report here. We
22 are kind of in the healthy smile business
23 and we -- a lot of the dentistry down here
24 is, you know, we are trying to build a
25 healthy foundation, you know, by treating

1 cavities, gum disease, occlusal disease,
2 replacing teeth -- maintaining teeth
3 positioning, but, you know, we want to try
4 to help people. And I just wanted to --
5 was reading an article and other articles,
6 but this one kind of caught my eye about
7 the association of periodontal or gum
8 disease with other systemic condition.
9 That's the title of the article. It was a
10 by directional relationship with other
11 health issues. Kind of related to how the
12 oral health relates to diabetes, rheumatoid
13 arthritis, heart disease and other oral --
14 other related health issues related to oral
15 health. This article came out of the
16 National Center for Biotechnology
17 information in association with the
18 National Institute of Health through the
19 National Library of Medicine and, also, in
20 association with work being done by Boston
21 University School of Dental Medicine.

22 One of the -- and I want to try to be
23 quick and brief on this, but just to give
24 you an example on things, but part of the
25 article talked about probing depth is a good

1 indicator of the advance of the disease of
2 gum disease. Of course, dentistry, also,
3 you have to look at the X-rays. You look at
4 the color texture of the tissues. You know,
5 you count in the fact, are they diabetic or
6 have other health issues that could advance
7 the disease. This was a new item that they
8 put out in this article, was this -- that
9 clinically patients with periodontal pockets
10 of four millimeters or more are now to be
11 diagnosed with periodontitis. The gold
12 standard used to be the five-millimeter
13 pockets. And in some circles, it may still
14 be five millimeters. But my question is, is
15 why do we wait until there is bone loss to
16 start treating this common disease?

17 Some form of periodontal or gum
18 disease affects 75 to 90 percent of the
19 global population. My wife said the other
20 night -- I was kind of reading some of this
21 to her, and she said, that's gross. And it
22 can be. But left untreated, gingivitis
23 progresses into an irreversible
24 periodontitis, resulting in tooth loss and
25 gum abscesses. And, again, we just -- we

1 got to stress it, we are in the healthy
2 smile business and, you know, we want to
3 just try to get people healthy.

4 Now, this is just an idea that I had
5 on starting to treat gum disease in our
6 Medicaid population, is to -- and I was
7 looking at some of the criteria on some of
8 our MCOs. And, you know, their -- some of
9 their criteria is spot on. It's really
10 good. But my idea would be to develop a --
11 with our patients, a one-year plan of action
12 that the patient would sign as a treatment
13 agreement. Now, you know, they will do -- I
14 guess the signature would mean that we are
15 trying to get them some buy in on their
16 care. You know, this care would obviously
17 include a full mouth X-ray series,
18 periodontal charting, hard and soft tissue
19 exams, diet, smoking counseling. And I
20 think we need to add in a behavioral health
21 component. Now, if this agreement is done,
22 you have got your charting, but that -- to
23 alleviate some of the paperwork that a lot
24 of the dentists and dental offices have to
25 go through is that if they are in this

1 agreement and sign this document, well, then
2 no preauthorizations would be required
3 through the MCOs or the fee for service
4 patients. We would continue to use the same
5 scale, root planing, appropriate codes like
6 your D4341s and 42s, but we would also need
7 to look at a robust code or adding a code in
8 of a D4345, which is a full mouth
9 debridement to enable an exam. Now,
10 sometimes that examine I think is just used
11 for pregnant lady. But when you deal with
12 young people that come in and they have
13 acute necrotizing ulcerative gingivitis,
14 these people are sick. They have a fever,
15 malaise, they are hurting, they can't eat,
16 they don't feel well. And sometimes --
17 sometimes before you can even get your probe
18 in -- well, number one, I wouldn't even
19 start to probe somebody that's got this
20 acute necrotizing ulcerative gingivitis.
21 They can't stand it. But anyway, to look at
22 this full mouth debridement, just to help
23 them get out of pain and the disease
24 process, starting to cure it, add in a code
25 of D4921, gingival irrigation with a

1 medicinal agent, add in the code D4910,
2 which includes -- which this would include a
3 cleaning every three months for one year.
4 This is a one-year plan.

5 Another behavioral component of this
6 would be that the plan would have no failed
7 appointments by the patient. And after one
8 year, to reprobe and do a reevaluation of --
9 to see if those periodontal measurement
10 numbers are getting better.

11 Now, other codes and some of these
12 that I have already mentioned, they have
13 already been added this year, but others
14 could be added to just let us -- or just
15 help us treat this disease.

16 Now, you know, an idea that I had,
17 too, is, you know, instead of getting
18 patients just to walk in the door and give
19 them a gift card, let the patient earn that
20 gift card now, after they have completed
21 that year plan. Not just for showing up,
22 but just to give them that reward, you know,
23 if they complete the treatment plan. Also,
24 I would recommend pay your providers a
25 descent and fair fee, you know, that the MCO

1 can't go below. We have got to do some
2 changes to move Kentucky from the 49th in
3 the nation on oral healthcare. We got to
4 move that up. We've got to do something
5 different and we've got to just change the
6 attitude of oral healthcare, you know,
7 whether it be with administrations,
8 administrators, the dentists, the public.
9 And this is something that you don't do
10 overnight, but just -- we want to just help
11 our patients help us treat the disease.
12 Now, that's -- I just want to give just some
13 ideas of trying to get us out of this 49th
14 position in American. I just put that out
15 there as an idea and it -- it can be
16 ignored, it can be modified -- and I know
17 most ideas tend to get modified and that's
18 okay, but I just want to get to us start
19 thinking about ideas that we can do to move
20 from 49th on up. I'll guarantee you, it
21 will take a while to get to number one, but
22 we got to start somewhere.

23 Now, are there any questions or
24 comments about that brief report?

25 (No response).

1 DR. BOBROWSKI: I'll move on.

2 Now, I want to go to old business.
3 And I put on the agenda, I said, please,
4 don't shoot the messengers. Sometimes I
5 feel like we as TAC member -- TAC members
6 are -- you know, we bring questions from our
7 self. We bring questions from a lot of our
8 patients. We bring questions from other
9 dentists and other healthcare providers that
10 we need to bring before you and let the TAC
11 look at it. And then make some resolutions
12 to go before the MAC.

13 The -- and I wanted to, again, thank
14 the Commissioner Lee, you know, for working
15 with the TAC and others, and other groups
16 to, you know, help increase our access to
17 giving care. It is very well appreciated as
18 she, you know, listens to us and has these
19 concerns that we do.

20 One thing -- and I know -- I think the
21 Commissioner said that she may have to leave
22 early. And before I get into a lot of this
23 other, I'd like to have the time if
24 Commissioner Lee would like to speak now or
25 after while, either way. So Commissioner,

1 would you like to have the floor for a few
2 minutes?
3 MS. SHEETS: Dr. Bobrowski, this is Kelli
4 Sheets. I'm sorry, the Commissioner did
5 have to step away already.
6 DR. BOBROWSKI: Okay.
7 MS. SHEETS: So I apologize.
8 DR. BOBROWSKI: Okay.
9 MS. SHEETS: You also need to make sure you
10 approve the minutes from the January
11 Emergency Meeting and the November 4th
12 meeting, so just a reminder of that.
13 DR. BOBROWSKI: Yes, yes, thank you so
14 much.
15 MS. SHEETS: You're welcome.
16 DR. BOBROWSKI: Why don't we do that right
17 now. We've got a quorum for our TAC
18 members. Let me write this down here. Let
19 me make a note here. Okay. Well, I'd like
20 that just for the TAC members, I'd like to
21 entertain a motion to approve the minutes,
22 you know, from the November TAC meeting,
23 and then also from the January meeting.
24 DR. PETREY: I second the motion.
25 DR. SCHULER: Did you do motion made first?

1 Yeah, that's okay. I'll make a motion to
2 accept the minutes from the November
3 meeting and the emergency January meeting.
4 And, Joe, you can second or somebody.
5 DR. PETREY: Second.
6 DR. BOBROWSKI: All right. Thank you,
7 Guys. All in favor say aye.
8 (All respond aye).
9 (Jean is in here, too)
10 DR. BOBROWSKI: Any opposed?
11 (No response).
12 DR. BOBROWSKI: Okay. I believe we got
13 that, but I'm going to go on down. The --
14 we kind of wanted to look at the codes and
15 reimbursement rates a minute here. And,
16 boy, I hate to admit this, but I spent
17 hours of time just going through the new
18 2023 FFS Fee Schedule. And I even expanded
19 it out into Excel and I was making some --
20 you know, there was some typos in there. I
21 was just going to go through and see what I
22 could do to be helpful, and spent two or
23 three days on it, several hours each day
24 going through things. And I've got it
25 all -- I sent it to the TAC and I sent it

1 to Commissioner Lee. And then somebody
2 else later on said, well, where's your
3 stuff? And somehow, I guess when I sent
4 it, columns on me and then it stuck
5 everything at the very bottom of the report
6 instead of lined up with each code number.
7 And it's -- you know, when you work on
8 something like that for hours and hours
9 and, boy, just -- and then that happened,
10 and it just took the wind out of my sail.
11 And it just like took somebody took my face
12 and shoved it in the mud hole. But it
13 just -- anyway, we are going to work on
14 trying to update that and -- but I would
15 encourage all the TAC members to kind of
16 look over that fee list. And, of course,
17 there's some typos in there that were in
18 the previous years that just kind of got
19 carried over. But I think since this is a
20 state document, we can update it and...

21 At this time, I want to look at our --
22 I've got it on the agenda as old business of
23 your fees and reimbursements. One of the
24 things I noticed -- and I've already made
25 the Commissioner aware of this when I sent

1 all this stuff in previously, but there's
2 even some codes in there like a D2394, which
3 is a four-surface composite filling code.
4 There was nothing listed down in the new fee
5 list. When I went back and compared it some
6 of the older lists, it was there, but those
7 are some things that we just need to tidy up
8 our list. And if our TAC members could look
9 at those and just see what else we could
10 help work on that.

11 Now, TAC members, does anyone else
12 have any comments on the fees and
13 reimbursements so far?

14 TAC MEMBER: (Inaudible).

15 DR. BOBROWSKI: Whoever just spoke, I could
16 not understand you. It was muffled.

17 TAC MEMBER: (Inaudible).

18 DR. BOBROWSKI: Okay. I still could not
19 hear that. Can anyone else hear it better?

20 DR. SCHULER: I cannot hear it at all.

21 DR. BOBROWSKI: Okay. Phil, Dr. Phil, did
22 you have any other comments so far on fees,
23 reimbursements?

24 DR. SCHULER: Well, I know there's some
25 confusion about some of the fluoride codes

1 and, you know, having to wait a number of
2 weeks after we do a fluoride, but I think
3 there was some confusion as to which
4 fluoride codes we were looking at. I think
5 one was diamine fluoride, which you don't
6 want to do diamine fluoride on a tooth and
7 then, you know, restore it, you know, a
8 week later. But, you know, some of
9 these -- some of the full-mouth fluoride
10 treatments, there shouldn't be a
11 restriction on doing restorative, you know,
12 after that for -- I think the restriction
13 was three months, if I remember correctly.
14 And I don't have the code numbers in front
15 of me. Sorry.

16 DR. BOBROWSKI: Let me see. I can look it
17 up here.

18 DR. SCHULER: You know, there was a waiting
19 period after restorative after fluoride
20 treatment, which didn't make a whole lot of
21 sense to me.

22 DR. BOBROWSKI: On the --

23 DR. SCHULER: And I had -- and I had the
24 same question about the four-surface
25 posterior composite missing.

1 DR. BOBROWSKI: On the fee list that I got
2 up here, this was revised January 30th. On
3 the fluoride there, I don't see anything.
4 Are you finding that, Dr. Phil, in the MCO
5 manual?

6 DR. SCHULER: No, I think it was on the one
7 that was from -- I think it was it -- it
8 may have gotten cleaned up on the next
9 version.

10 DR. BOBROWSKI: Okay. It just shows on the
11 fluoride, they say the exact same thing,
12 whether it be a fluoride varnish or a
13 topical application of fluoride. It's just
14 limited to two per 12 months per member per
15 provider. And that's the same -- I don't
16 see any other restriction on there.

17 DR. SCHULER: Yeah.

18 DR. BOBROWSKI: And like I said --

19 DR. SCHULER: Did you -- did you talk to
20 the Commissioner -- yeah, did you talk to
21 the Commissioner about the prior
22 authorization for the -- was it periodic
23 exam code that was on there initially?

24 DR. BOBROWSKI: I did not. It's now --
25 yes, up there. It's the -- yeah, it's the

1 D0120 periodic oral exam. Oral evaluation
2 requires prior authorization one per six
3 months. I sent that in to her, but I did
4 not talk with her about that particular one
5 yet. And I believe --

6 DR. SCHULER: Well, I can't imagine that
7 the MCOs are going to be...

8 DR. BOBROWSKI: Yeah, I don't even remember
9 that being on...

10 DR. BRAUN: This is -- this is Carol Braun.
11 I know I noticed that as well, because
12 historically D0120 wasn't a covered
13 service. You had to use the D0150 for each
14 encounter. And so I just wasn't quite sure
15 how to direct my staff to code out exams,
16 so...

17 DR. SCHULER: Yeah, if we could get some
18 clarity on that, Garth, that would be good,
19 because obviously, the MCOs, you know,
20 can't even handle -- I mean can you imagine
21 having to preauthorize every periodic exam
22 in the state?

23 DR. BRAUN: Well, and then also for the
24 D0150 to be limited to one every 12 months,
25 that's not something that had happened

1 before either. So I -- you know, it's a
2 little bit confusing on that.
3 DR. CAUDILL: Garth, this is Jerry.
4 DR. BOBROWSKI: Yes, go ahead.
5 DR. CAUDILL: Avesis does not require a
6 preauthorization for the D0120. And we
7 made the same suggestion to DMS that you
8 did.
9 MS. LOCKE: This is Loren --
10 DR. SCHULER: I know --
11 MS. LOCKE: Oh, I'm sorry.
12 DR. SCHULER: No. You're fine. Go ahead.
13 I'll --
14 MS. LOCKE: I was going to go ahead. This
15 is Loren from DentaQuest on behalf of
16 Anthem. We are not requiring the prior
17 authorization either.
18 DR. SCHULER: Yeah. But if everything on
19 the new code list -- I'll be honest with
20 you, that was the one that had everybody
21 about as riled up as you could be, just
22 because the amount of paperwork. And,
23 obviously, we don't have the capacity and
24 the MCOs evidentially either, so we got
25 DentaQuest and, you know, Avesis are not

1 going to -- are not going to require that.
2 So I guess we get -- United Healthcare will
3 be in business.
4 DR. RICH: I don't know if you can hear me.
5 DR. BOBROWSKI: Yes, we can.
6 DR. SCHULER: Yeah, we got you.
7 DR. RICH: Yeah, we don't be requiring
8 that.
9 DR. BOBROWSKI: Well, thank you all --
10 DR. SCHULER: Sounds like it's a moot
11 point.
12 DR. BOBROWSKI: Cleared that up real quick.
13 Thank you all so much. And, of course,
14 basically on D0150, I mean that's -- is
15 what I understand, that was one -- you
16 could only use it once a year, which that's
17 basically what it says out there in the
18 notes is one per 12 months per member per
19 provider.
20 DR. CAUDILL: What you can do there then is
21 for the second one each year, you can use
22 the 120, though.
23 DR. BOBROWSKI: Right. Yes. So Dr. Phil,
24 that's how I do it, is I use the D --
25 the D0150, you know, like I said, at the

1 first of the year. And then -- or well --
2 for their first appointment. Then in six
3 months, we just use the D0120. You just
4 have to tell your front office staff, make
5 sure they are doing that correctly.

6 There was some of the wording on these
7 fee lists, is what I was looking at,
8 sometimes it can be just a little un -- a
9 little confusing or -- especially in this
10 day and time when you have staff turnover,
11 just training them on things to -- how to
12 file things and not try to eliminate the
13 refiling things and there -- and I know one
14 of the questions was, why is there a
15 different fee for like a upper denture as
16 compared to a denture fee on the lower
17 denture? And what I was told was that,
18 statistically, when you -- when they look at
19 the national trends of the payment on
20 dentures, the upper denture typically was
21 charged more by dentists than the lower
22 denture. Now, I don't know, when I -- when
23 I -- dentures to patients, I -- you know, I
24 tell them, it's the same price for each
25 denture. You know, I don't know why

1 dentists have two different prices for
2 the -- basically the same procedure, just a
3 different arch. If anybody knows that
4 reason, chime in. But there was another
5 one --
6 DR. SCHULER: We do it just like you
7 described, Garth. I mean, it's the same --
8 DR. BOBROWSKI: Okay.
9 DR. SCHULER: -- it's the same teeth for
10 the top or the bottom.
11 DR. BOBROWSKI: Yeah. See there -- here's
12 just an example of one of the wording
13 changes that I had recommended was under
14 denture relines. Well, there's plenty of
15 room to kind of spread those out, but it's
16 a D5731. It says, denture reline complete
17 mandible direct -- or it's spell -- they
18 just put D-I-R. Well, the next code is a
19 D5740 and it just says, reline maxillary.
20 Well, that's a partial denture, but it's
21 almost like -- and down there is the word
22 for reline complete maxillary denture, a
23 D5750, but just some of the wording, I
24 think, you know, could just be matched up a
25 little better. And I'm just looking at it

1 from helping to train staff and, you know,
2 as we look through there on those codes.
3 Let's see. Did John Gray ever get on the
4 call? He's our oral surgeon. I was just
5 going to ask if he had any questions on any
6 of the oral surgery codes.

7 DR. SCHULER: I have not heard any comments
8 coming from our oral surgeons, other than,
9 thanks for the increase. I mean, that
10 was -- that was nice, but I've not heard
11 any confusion or anything that didn't make
12 any sense from any of my folks.

13 DR. BOBROWSKI: Okay. Good. Now, I don't
14 see it on this new code list. But on some
15 of the previous ones, back earlier on in
16 January, that was what I put on there.
17 There was a column that was kind of -- it
18 was marked in green out to the side. Is
19 there anybody from the state -- I don't see
20 it on the new one, but what was that for?
21 I never could find out what that green
22 column was for.

23 DR. SCHULER: The green column was -- the
24 green column was for the codes and the fees
25 that were going to be shared between oral

1 surgery and GP. So if it had a green code,
2 that was the same code for oral -- for oral
3 surgeons and GPs. If it didn't have a
4 green column or a green square next to it,
5 then that fee only applied to oral
6 surgeons. That was my understanding.

7 DR. BOBROWSKI: Okay.

8 MS. KITCHEN: This is Kelly Kitchen with
9 DMS. Can you hear me okay?

10 DR. BOBROWSKI: Yes.

11 MS. KITCHEN: Okay. So that is correct.
12 The green column --

13 DR. SCHULER: You are breaking up a bit.

14 MS. KITCHEN: -- was put there for the oral
15 surgeons. And we moved that piece to the
16 lower portion of the fee schedule. As far
17 as the wording that you are speaking of,
18 DMS received a file from the AMA, from CMS
19 that lists a short description of a code,
20 and, also, it lists a -- I'm sorry, from
21 the CD -- from the ADA. It lists a short
22 description and a long description, so
23 we -- most of the time, we use a short
24 description, but we can definitely look at
25 updating that to use the long description

1 that would make more sense.

2 DR. BOBROWSKI: Sometimes when you are just
3 going down through there and -- you know,
4 and looking at things, just on making stuff
5 just easier to find.

6 MS. KITCHEN: Absolutely. Absolutely.

7 DR. BOBROWSKI: We'll just have to talk to
8 that ADA about that stuff. No, I'm joking.

9 Now, are there any other comments or
10 questions about anything of these other
11 codes and things?

12 I think some of that has -- well, I
13 guess the other thing is, like on -- and I
14 did mention this to the Commissioner, on
15 like dentures, partial dentures. Now, yes,
16 some of the codes are -- the requirements or
17 preauthorizations are done by the MCOs, but
18 what are the guidelines, preauthorization
19 requirements, et cetera for patients that
20 are on the fee for service? Because some of
21 those -- of course, those little squares
22 don't have a lot of room, but how do we find
23 out that information? Because we've got
24 people calling every day wanting, you know,
25 partial dentures or a denture or whatever

1 and we are a little hesitant to start
2 something, because we don't have all the
3 guidelines printed out somewhere yet that I
4 can find.

5 MR. DEARINGER: This is Justin Dearing
6 Department for Medicaid services. And
7 Kelli can correct me if I'm wrong. I
8 thought we had covered this before multiple
9 times, but, you know, you talk about
10 something so much you forget exactly where
11 you talk about it. And so we have -- maybe
12 we should put out some guidance, I guess,
13 on the website, because I think this has
14 come up multiple times. But all of the
15 requirements that we have are listed on the
16 fee schedule. They are right there in that
17 column. If there's not anything there,
18 there are no requirements for that
19 particular code. We do have prior
20 authorizations where we use, you know,
21 clinicians to review for appropriateness.
22 And then all codes are open for auditing to
23 look for medical necessity. But if it's
24 not listed on that fee for schedule -- fee
25 schedule or fee for service fee schedule,

1 then there's nothing for that particular
2 code.

3 And if you see something that you may,
4 you know, think, well, I think there should
5 be something there. You know, like we have
6 said, feel free to reach out and submit that
7 information -- along with all the other
8 codes that you have talked about up to this
9 point, submit that to us and we would be
10 more than happy to look at that. And, you
11 know, since this is a first time fee
12 schedule, I know we are not making any
13 changes for a while to it, because at some
14 point we had to stop and say, this is the
15 fee schedule. But we usually do change the
16 fee schedule once per year. However, for
17 this one, since it's new, we may consider
18 doing something after six months or so, but
19 we need to have all those -- all the
20 information. And, absolutely, if it's a
21 typo, we can change that, because it's
22 already changed in the system one way.

23 Any time we make a change to the fee
24 schedule, we have to make a change to the
25 system as well, which usually takes a number

1 of months and is usually a price tag
2 involved, also, but -- so anything that you
3 feel like that's missing or been left off,
4 we encourage you to write that, send that to
5 myself or the Commissioner, either one, and
6 we will review that and see what we can do.
7 On this six months that rolls around, maybe
8 we can do an update at that time.

9 DR. BOBROWSKI: Would you mind to give us
10 your e-mail address then so we can send
11 stuff -- we can send it to you and copy the
12 Commissioner or vice versa?

13 MR. DEARINGER: Absolutely. I'll put it in
14 the chat right now.

15 DR. BOBROWSKI: Okay. Good. Thank you
16 very much, Justin.

17 MS. SHEETS: And, Dr. Bobrowski, I'll send
18 that out to the TAC members as well
19 following the meeting.

20 DR. BOBROWSKI: Okay. Great. Thank you.
21 Let me make a note here. Well, just for
22 sure, there's -- down under that D2394,
23 there's no fee listed for four resin, four
24 or more services posterior. And I know --

25 MR. DEARINGER: Yeah, I heard you -- yeah,

1 I heard you talk about that one earlier.
2 That -- again, that may be a typo. We
3 just --
4 DR. BOBROWSKI: Yeah.
5 MR. DEARINGER: -- have to go in and look
6 and see. But get those together, we'll
7 look at those. If it's anything that's a
8 typo we have just accidentally left off on
9 the fee schedule, we -- it's probably
10 already in the system, so we just add that
11 to the fee schedule and we are good to go.
12 Any other suggestions we can look at
13 possibly? Like I said, since it's a brand
14 new -- I understand it's not a brand new
15 fee schedule, but it's -- you know, it's a
16 brand new fee schedule in the sense that we
17 have created an additional, you know,
18 additional group of people to be serviced.
19 And we have also included a lot of
20 additional codes and pricing. And because
21 of all that, we may want to do a revision
22 at the six-month mark, which is not
23 something we normally do, but with this
24 one, I think we might need to. But, yeah,
25 absolutely send me that. I've got that one

1 already, but you can send me that one and
2 all of them that we've talked about -- or
3 any that you see after this, if you want
4 to, you know, encourage the TAC to go back
5 and relook at anything they may have a
6 question about, any suggested improvements,
7 anything like that, we are always -- and
8 it's not just for this fee schedule.

9 It's something that I try to tell all
10 provider types. We are always open. We
11 get -- we constantly get e-mails from
12 providers, from provider advocate groups,
13 from TACs, from MCOs, asking about different
14 codes or pricing or requirements. And so we
15 are always looking at -- and doing research
16 on requests we get and suggestions we get
17 from the provider community about all types
18 of different things. So this is something
19 that is built into our process and our
20 program and we look forward to it.

21 DR. BOBROWSKI: There's -- you know, in my
22 little report this morning on treating the
23 gum disease -- and I've already mentioned
24 this to the Commissioner, but, you know,
25 down there in treating gum disease, you

1 know, the -- I know the fee is a D4341.
2 And I know the MCOs and the fee for
3 service, it does require prior
4 authorization. One thing that I know some
5 of the MCOs require is, is that we can only
6 preauthorize two quadrants at a time. This
7 is a new change over the last few years,
8 but instead of preauthorizing the -- and if
9 somebody from one of the MCOs wants to
10 chime in here in a minute, please do.

11 But it's just that by not being
12 allowed to do all four quadrants at one
13 time, then we get two done, then we got to
14 go back and it just takes up more time from
15 our front office staff to then, well, we got
16 to send in two more quadrants to get done on
17 you. It's kind of like the old way of just
18 get in there and get it done. And most -- I
19 don't know, the way we do it or in our
20 office. We usually do two quadrants at a
21 time. But I'd just like to decrease the
22 paperwork time it takes the front office
23 staff, so that -- if the MCOs would just
24 consider doing one preauthorization would be
25 nice, but on the other hand, looking at

1 those -- the 4342, sometimes to get somebody
2 in and numb them, deep scale them, put a
3 medicated caved rinse on them, and the fee
4 for the adult is \$26. I can't do it for
5 that. Therefore, I can't treat the disease.

6 So, you know, these are -- to me, this
7 is just as much of a preventive process, a
8 preventive treatment code to help prevent
9 the disease from getting worse. Yeah, it's
10 not through their whole mouth, but it's in a
11 section of one to three teeth. Typically,
12 it's around the molars. But I can't do it
13 for \$26, so we need to -- we need to look at
14 that fee on that one. And I have mentioned
15 that to the Commissioner on that one.

16 MR. DEARINGER: Was that the 4341? Is that
17 what you're...

18 DR. BOBROWSKI: Well, the 4341, that --

19 MR. DEARINGER: That was the prior
20 authorization. So what was the code?

21 DR. BOBROWSKI: Right. Well, it's the
22 D4341, that -- the fee on that one is only
23 that \$78, you know, for an adult. And it's
24 paid at 101.40 for a child. I don't -- in
25 all my years of doing dentistry, we don't

1 have to do much root planing on children or
2 teenagers, but that -- that's another fee
3 that needs to be looked at or, at least,
4 raised up to the children's rate. And then
5 the D4342, if you really want to get
6 serious about treating gum disease, you got
7 to get it to where, you know, it costs them
8 that much just to do the paperwork for some
9 of this stuff. And --

10 DR. SCHULER: Hey, Garth?

11 DR. BOBROWSKI: Yes, go ahead.

12 DR. SCHULER: Before we get, you know, off
13 of fees, I was asked by some of our
14 leadership on the oral surgery side about
15 implant codes. I have not seen implant
16 codes on the fee schedules, so is that -- I
17 don't know if it's on the 130 revision that
18 you had talked about, but patients are
19 obviously asking a lot about implants. But
20 at this point, I don't think we have got a
21 lot of guidance on, you know, what's
22 covered. And I mean, I've talked to
23 Dr. Caudill about, you know, some of the
24 clinical requirements, but I don't know if
25 they are listed on that fee schedule or --

1 DR. BOBROWSKI: Yeah.

2 DR. SCHULER: -- even if the code was

3 listed.

4 DR. BOBROWSKI: Yeah. There was an

5 endosseous implant code. Right there, it's

6 a D6010. Now, it -- endosteal implant

7 is -- it says prior authorization required.

8 Implant must be based on last resort.

9 Dentures that are causing damage or not

10 wearable due to medical reasons, once per

11 tooth per lifetime. So somehow, if you get

12 the preauthorization passed through, it

13 would probably be like where the -- you

14 would have to probably write a narrative

15 where the denture is either causing damage

16 to other tissues or just flat not

17 wearable --

18 DR. SCHULER: Yeah.

19 DR. BOBROWSKI: -- due to a medical reason.

20 And I guess the fact that there's no ridge

21 left would be a medical reason and they

22 have already tried a denture. Any of the

23 MCOs got a comment on that part yet?

24 DR. SCHULER: I think as long as it has to

25 be preauthorized, we'll -- I mean, these

1 are obviously going to be few and far
2 between. I mean, the patients think that
3 every time they have a tooth missing, they
4 are going to be to get a -- you know, a
5 free dental implant and that's not going to
6 be the case.

7 DR. BOBROWSKI: Right.

8 DR. SCHULER: And as long as we got a
9 preauthorization process to go through, you
10 know, we'll work through it on a case by
11 case. I just wanted to make sure it was on
12 there.

13 DR. BOBROWSKI: Yeah. The -- and I know --
14 let's see the -- you know, and a while ago
15 when I was giving my report, I know -- and
16 I -- we do a -- and, Dr. Phil, it's just
17 like the -- I know you all do a lot of gum
18 treatments. We do, too. And they've
19 added -- they have added in the code the
20 D4910, which is a periodontal maintenance
21 procedure. And if you are going to treat
22 gum disease, I know it's standard of care
23 to have a cleaning done at the -- and,
24 typically, it's at the gum specialist, or
25 sometimes they will alternate every three

1 months with the general practitioners
2 office for just getting a good cleaning
3 done, and then they do monitor the perio
4 probing, so -- but now, this is -- what's
5 on here is for the fee for service. And to
6 be honest, I haven't looked at the new fee
7 for service for the MCOs to make sure that
8 the MCOs are going to follow through with
9 that, too.

10 But those are -- those are some codes
11 that are being added that I know as a
12 practicing dentist, that those are
13 appreciated because we can -- we can
14 actually help our patients more by doing
15 this follow-up care than we could in the
16 past. So that is appreciated. And I wanted
17 to say a thank you again.

18 DR. CAUDILL: Dr. Bobrowski?

19 DR. BOBROWSKI: Yes.

20 DR. CAUDILL: This is Bob Caudill. On the
21 periodontal maintenance?

22 DR. BOBROWSKI: Yes.

23 DR. CAUDILL: Avesis did reach out to both
24 the University of Kentucky College of
25 Dentistry and University of Louisville

1 School of Dentistry. I spoke directly with
2 the head of the periodontal department in
3 both dental schools. Avesis is recognizing
4 periodontal maintenance every three months.
5 DR. BOBROWSKI: Okay.
6 DR. CAUDILL: Following -- following --
7 DR. BOBROWSKI: Thank you very much.
8 DR. CAUDILL: -- following, you know,
9 definitive periodontal therapy.
10 DR. BOBROWSKI: Yes, yes, yeah. But do
11 you-all -- Dr. Caudill, in your research --
12 and I know you have been a practicing
13 dentist, too. Am I correct in saying that
14 that three-month followup is pretty much
15 standard of care to help keep the disease
16 process to a minimum?
17 DR. CAUDILL: That's what both dental
18 schools said, yes. That is still the
19 standard of care.
20 DR. BOBROWSKI: Good deal. Good deal.
21 DR. CAUDILL: And that's what they are
22 still teaching at both dental schools.
23 DR. BOBROWSKI: I'm going to make a note
24 here. Well, thank you all for that.
25 DentaQuest and United Healthcare, have

1 you-all had a chance to look at that code?
2 MS. MEDINA: This is Christy from
3 DentaQuest. Yes, we are basically in
4 agreement with Dr. Caudill and Avesis'
5 approach there for those codes. Yeah.
6 DR. BOBROWSKI: Thank you very much.
7 DR. RICH: Yeah, this is Dr. Rich with
8 United Healthcare. We are following the
9 standard of care guidelines as well.
10 DR. BOBROWSKI: Okay. I hate to --
11 DR. SCHULER: Hey, Garth?
12 DR. BOBROWSKI: Yeah, go ahead.
13 DR. SCHULER: Could we maybe talk to the
14 MCOs about that four-surface posterior
15 composite. I mean, even though --
16 DR. BOBROWSKI: Yeah.
17 DR. SCHULER: -- even though it may not be
18 on the -- you know, even though it may not
19 be in the state fee for service fee
20 schedule. Is that something that they will
21 continue to cover? We can't -- because I
22 mean if it was a typo, and it was like it
23 was left off for real, we can't wait six
24 months for that to be a covered procedure.
25 We do a lot of for service posterior

1 restorations on this population.

2 DR. BOBROWSKI: Yes.

3 MS. MEDINA: So I know that for DentaQuest,

4 you know, if something is not covered yet

5 it's medically necessary, under EPSDT it is

6 payable. So just kind of really depend --

7 you know, even though it's not on the fee

8 schedule, there are those instances where

9 it should be allowed.

10 DR. CAUDILL: And it could be allowed under

11 children EPSDT, but that would not affect

12 the adults. And actually, the state's fee

13 schedule is showing -- I'm looking at it

14 right now online. It's showing it's

15 covered for children, but not for adults.

16 It says N/C, so...

17 DR. BOBROWSKI: Right.

18 DR. CAUDILL: I guess we are all hoping

19 that's just a typo that they can quickly

20 fix.

21 DR. SCHULER: Yeah, because that's one,

22 Garth, I mean, we need to -- we need to get

23 an answer on that one pretty quick, because

24 can you imagine how many four surface

25 composites are done on Medicaid patients in

1 this state.

2 DR. BOBROWSKI: I do a ton of them, you

3 know, and --

4 DR. CAUDILL: And the problem is, a lot of

5 dental offices don't even have an

6 amalgamator. They don't do silver fillings

7 any more. They only do composites.

8 DR. BOBROWSKI: Yeah, right.

9 DR. SCHULER: Right.

10 DR. BOBROWSKI: Yeah. Now, Dr. Caudill,

11 are you-all still just doing it under -- as

12 a EPSDT at the --

13 DR. CAUDILL: Until the code is changed,

14 you know, we are following exactly what's

15 printed, yeah.

16 DR. SCHULER: But, I, mean to have to go

17 through the EPSDT for every single one of

18 these would be -- that's a burden.

19 DR. RICH: Yeah, but that's not -- my

20 understanding -- this is Dr. Rich -- that

21 code is always been covered for under 21.

22 And EPSDT only cover under 21. It's the --

23 MS. MEDINA: YEAH.

24 DR. RICH: -- adult that it's not been on

25 the fee schedule for and --

1 DR. SCHULER: There you.

2 DR. RICH: But UHC has been covering it for

3 adults, but it's not on the fee schedule,

4 the prior fee schedule or this one. It

5 doesn't really make any sense. I don't

6 understand that either. I think we are all

7 in the same quandary as to why it's not

8 covered, but it is covered for UHC members,

9 I know that.

10 DR. BOBROWSKI: I'm going to put this down

11 just a second. I'm going to look something

12 up here.

13 DR. SCHULER: While Garth is looking that

14 up, Dr. Caudill, did I understand that if

15 it's not on the fee schedule, you are not

16 covering it?

17 DR. CAUDILL: I believe that's what I was

18 told on the last version of our fee

19 schedule, that.

20 DR. SCHULER: Yeah.

21 DR. CAUDILL: You know, we are following

22 DMS exactly.

23 DR. BOBROWSKI: Justin, I want to hopefully

24 that -- I know it's Friday afternoon, but,

25 boy, we've got to get this one figured out.

1 MR. DEARINGER: Yes, sir. Yeah, as I --
2 like I said, you know, I don't know if we
3 will -- it's 3:00 on Friday afternoon.
4 We'll do our best to try to get an answer
5 for you-all as soon as possible.
6 DR. BOBROWSKI: Okay. Appreciate that,
7 because --
8 MR. DEARINGER: Absolutely.
9 DR. BOBROWSKI: -- yeah, to follow up and
10 see if it's a typo or it is just
11 accidentally got left off. Because out
12 here in our world, we have a lot of folks
13 come in with, you know, whole sides of
14 teeth busted out or decayed out and we do a
15 lot of that type of repair. And it's --
16 and we are six weeks or so into the new
17 year and it's untelling how many times that
18 code has been used.
19 DR. SCHULER: Can we get a comment from
20 DentaQuest? I think that's the only one
21 that we really haven't heard from.
22 DR. BOBROWSKI: I think she said they use
23 the EPSDT.
24 DR. SCHULER: But you can't do that on
25 adults, right?

1 MR. DEARINGER: Yeah, EPSDT --
2 MS. MEDINA: Right. Sorry.
3 MR. DEARINGER: -- is children only.
4 MS. MEDINA: Yeah, it's children only, so
5 it would just go down to medical necessity,
6 you know, in the event there's like a true
7 medical need. Sometimes they will be
8 covered for adults.
9 DR. BOBROWSKI: Okay. I'm making a note
10 here.
11 DR. SCHULER: I hope so. I'm making a big
12 one.
13 DR. BOBROWSKI: Yeah.
14 MS. LOCKE: Hi, this is Loren from
15 DentaQuest.
16 DR. SCHULER: Yeah, we're six months --
17 MS. LOCKE: Sorry. I was just going to
18 add --
19 DR. SCHULER: Go ahead.
20 MS. LOCKE: -- that the -- they have been
21 covered for adults. We just require the,
22 you know, to show medical necessity, so
23 just perio charting and X-rays.
24 DR. BOBROWSKI: See, that's -- see, that's
25 the thing that bothers us practicing

1 dentists, is that, you know, historically
2 you know, if something walks in the door,
3 they have been up here at the restaurant at
4 lunch time and broke the side out of a
5 tooth and now you have got -- it's 1:00 in
6 the afternoon and you got to fix it. Well,
7 no, I may or may not have done a
8 periodontal exam, but I can see on the
9 X-ray that I don't see any bone loss. But,
10 you know, if I've got to send in a
11 preauthorization or a -- an X-ray and a
12 perio charting, you know, just to fix that
13 tooth and I can -- in my professional
14 judgment, don't see a bone problem or a
15 fracture that's going to cause the teeth to
16 be weakened, that's what I have a problem
17 with, is the paperwork that's involved with
18 just treating people. We have got to
19 figure this out. But the other thing is
20 this, and it's down here in new -- well,
21 no, it's here just in the next item. It's
22 like we -- we as Medicaid providers, we've
23 lost a ton of providers. And my question
24 is, how do we get them back? And, boy,
25 we -- you don't get them back by having a

1 bunch of paperwork and, you know, stuff to
2 send in. If you got somebody in healthcare
3 that's an outlier, you know -- you know, go
4 after them. And I've talked to other
5 practitioners and -- not even in dentistry
6 that sometimes the paperwork involved is
7 just denying treatment for people.

8 I mean, you take -- like if you have a
9 broken tooth right after lunch and you did
10 get into a dentist that afternoon, well,
11 would you want the dentist to say, I can fix
12 that but I got to wait until I get the
13 authorization back from the -- from your
14 insurance company or from your Medicaid
15 company. When can I get that back? Well,
16 how long does it take to get it sent in and
17 get an authorization back. But that's --
18 that's my problem, is just a practicing
19 provider. And that's the other problem, is
20 as other dentists drop out or limit their
21 services to the Medicaid program, then for
22 the ones like me and some other dentists
23 around and across the state, it's like we
24 try to do everything we can, but that puts
25 even extra burden on us as other people are

1 dropping out. And I'll tell you -- and it
2 was shown by Dr. McKee's presentation and
3 survey that, you know, these failed
4 appointments was another problem. We talked
5 to a dentist and he -- there's two dentists
6 in another town close by, but they have
7 limited their practice to like one four-hour
8 segment a week. I think I may have
9 mentioned this before, but he called me
10 again the other day about -- well, about
11 last week. They had 21 patients scheduled
12 in that time block. 10 of them didn't show
13 up. And, again, I think things we need to
14 look at -- and I'm going to ask the MCOs and
15 the State to kind of look at this, because
16 it's a factor that's causing dentists to
17 lose out. And I'm on the MAC. And this
18 failed appointment problem, it's a problem
19 across the State with multiple health
20 providers. And I think we need to get
21 creative and work with people. I understand
22 a flat tire happens. The car won't start.
23 I don't have a baby sitter. Life happens.
24 But, boy, there's just -- yesterday
25 afternoon, I had some other patients

1 scheduled and had three Medicaid patients.
2 None of them showed up.
3 DR. COLEMAN: Dr. Bobrowski?
4 DR. BOBROWSKI: Go ahead, Ronny.
5 DR. COLEMAN: Yeah, I'm going to say that
6 we have the same problem in every state.
7 And, in fact, we just raised this issue in
8 a legislative hearing yesterday in Indiana
9 about what could be done. And I mean,
10 people bounced it around and I -- it's just
11 really hard, because some people want to be
12 punitive against the patient. And then if
13 you do that, then they are not never --
14 they are not going to want to go the
15 dentist any way. They are not even going
16 to try. It's like a really hard nut to
17 crack, because it's everywhere. And, you
18 know.
19 DR. BOBROWSKI: Yeah, yeah.
20 DR. COLEMAN: You are lucky if you are in a
21 community where it's not a problem. The
22 other thing I wanted to just mention while
23 I'm on here is that you mentioned, you
24 know, what do we to keep dentists? Well,
25 just tell you, we closed our Broadway

1 office downtown Louisville, which we had
2 open for -- I don't know, maybe 18 years or
3 something like that. It served that
4 downtown community. You know, rates are
5 the main thing, but, you know, a lot of it
6 was the no-show and -- and, really, the
7 Pandemic. And then there's the crime down
8 there, I think, on contributed to
9 staffing not -- staff not wanting to work
10 there. But I just wanted you to know that
11 we did close that particular office about a
12 month ago -- or less than a month ago.

13 DR. BOBROWSKI: Well, Ron, I sure do hate
14 to hear that you had to close an office.

15 DR. COLEMAN: Me too. It's just hard to
16 keep providers.

17 DR. BOBROWSKI: Yeah, I understand the --
18 you know, and staffing issue is another
19 problem. Not only downtown Louisville, but
20 out here in the country. I think I
21 mentioned this before, I was talking with a
22 hygienist the other day, a few weeks ago
23 there, in the E-Town, with the Central
24 Kentucky area, there was 22 offices looking
25 for a hygienist. And I mentioned this to

1 the Commissioner. I'm down here in South
2 Central Kentucky close by to Lindsey Wilson
3 College in Columbia and Campbellsville
4 University over here in Taylor County. And
5 I'm kind of in between them, but I've been
6 thinking about trying to develop a sales
7 pitch and go to those universities and just
8 see and talk to them about opening up a
9 dental hygiene program. I know
10 Campbellsville University is -- they are
11 doing a lot of different types of program.
12 They just opened up a cosmetology program.
13 Lindsey Wilson just opened up a nursing
14 program. Maybe it's time to talk to them
15 about a dental hygiene program and get some
16 of our local young people interested in the
17 dental field, because with Covid -- Ronny,
18 that's what you said. Covid, it just kind
19 of knocked a lot of hygienists out of the
20 system role.

21 DR. COLEMAN: Yeah, they just baled out.

22 DR. BOBROWSKI: And I talked to another
23 dentist out in the western part of
24 Kentucky, but -- he's not a Medicaid
25 provider, but he said I went six months --

1 you know, he's been in practice 20 plus
2 years, 25 years, but he said, I went for
3 six months without a hygienist. So that
4 can really slow down the whole process of
5 treating patients when the dentist has to
6 sit in there and do that procedure for half
7 an hour to an hour. You know, you don't
8 get any of their fillings done or you don't
9 get that tooth pulled. So those are other
10 factors involved.

11 I want to --

12 DR. PETREY: Garth, if I can interject on
13 that real quick. I apologize --

14 DR. BOBROWSKI: Yeah.

15 DR. PETREY: -- for interrupting.

16 DR. BOBROWSKI: No problem.

17 DR. PETREY: I completely understand the
18 sentiment on no-shows and the worries about
19 no-shows. It is a critical issue, but I
20 think -- and I love your -- your concept
21 that we can -- we need to get creative on
22 how to address those. I think, however,
23 though, we are dealing with a patient
24 population that has a lot of constraints
25 against them, socioeconomically

1 specifically. And for us to anticipate
2 them to be in the same show rate as every
3 other individual, I think is a farce. I
4 also think that when we -- when we focus
5 and compare our patients, we need to be
6 very careful of that and what they are able
7 to achieve and what they are not able to
8 achieve. I think those of us that are on
9 this committee see high rates of these
10 patients. I think we get a lot of
11 complaints by from -- from individuals,
12 practitioners that do not see high rates of
13 the Medicaid population. And they complain
14 when comparing no-show rates of their
15 Medicaid population to their non-Medicaid
16 population. You get no-shows from every
17 economic status.

18 DR. BOBROWSKI: Yeah, yeah, yeah.

19 DR. PETREY: But when you compare the two,
20 it's unfair to the individuals that do have
21 a more difficult time in completing those
22 appointments.

23 For me, it all goes back to, how do we
24 get more practitioners to want to see more
25 patients? Why do we have so many no-shows?

1 Some of the no-shows, because they wait for
2 treatment, they have difficulty getting
3 treatment because there's not enough
4 providers. And so to address the problem, I
5 think we need to increase our providers and
6 increase the pay for those providers so that
7 each provider understands there will be a
8 higher no-show rate. In our clinics, we
9 have an 18 to 20 percent no-show rate daily.
10 We factor that in. When everybody shows, we
11 love it. It's a very difficult day when
12 they do, but we --

13 DR. BOBROWSKI: Yeah.

14 DR. PETREY: -- we factor that in. Why do
15 we factor that in? Because we want to see
16 our patients. And it is increasingly more
17 of a challenge, acutely becoming more
18 increasing and more of a challenge because
19 one of the very few orthodontic providers
20 in Eastern Kentucky that does accept
21 Medicaid, will close his practice in 10
22 days. That's going to add another
23 difficulty for those of us out there that
24 are trying to see his population. But if
25 we factor in that no-show, and we

1 understand that this population is going to
2 have that, but we are appropriately
3 compensated for the work that we are doing,
4 then we as practitioners need to accept
5 that no-show rate, try to improve it, but
6 understand it and be very careful. And I
7 know that you are not, but many blame the
8 patient when it's not always their
9 situation.

10 DR. BOBROWSKI: Right.

11 DR. PETREY: And if we could -- if we could
12 improve things such as the compensation for
13 the providers, we can improve the system,
14 we can increase the number of providers.
15 And we all will not have the worry. I love
16 treating the population. Would I like it
17 to be less of a percentage of the people
18 that I treat? Absolutely. But I'm going
19 to see who needs to be seen. And we are
20 going to have to factor in that no-show
21 rate. But we are not going to get young
22 dentists, young orthodontists, young
23 periodontists or oral surgeons to jump into
24 this game if they don't have an appropriate
25 compensation for what they are doing,

1 especially with the understanding that they
2 are the negative aspect such as no-show.

3 DR. BOBROWSKI: Yeah. Good -- good
4 comments. Thank you, Dr. Joe. Appreciate
5 them.

6 Any other ideas or -- on how do we get
7 providers back? I just call it, you know,
8 rebuilding our network. And, you know,
9 developing plans of care with patients and I
10 -- I put down same thing, fees and I -- and
11 you worded that really well on, you know,
12 just to acknowledge that there's going to be
13 a failed appointment problem. And -- but --
14 and just go into it knowing that. But
15 you're right, we've got to take care of
16 people. That's our job. That's our oath.

17 DR. SCHULER: Well, Garth, another --

18 DR. BOBROWSKI: Go ahead.

19 DR. SCHULER: Another big component to this
20 is the hygiene shortage. So --

21 DR. BOBROWSKI: Yeah.

22 DR. SCHULER: -- I mean, like you
23 mentioned, there's not nearly enough
24 hygienists to service, you know, the needs
25 of the population that's out there. And,

1 you know, you -- form an economic
2 standpoint, you just have to look at it and
3 go, I can see one population of patients at
4 a certain fee schedule. Maybe that's
5 Medicaid, which is, you know, half to a
6 third what we are -- you know, what we are
7 getting compensated for, you know, for fee
8 for service or, you know, PPO or any of
9 those other things. And I mean, you know,
10 we -- I can't imagine being, you know, an
11 experienced doctor without hygiene support
12 and, you know, your day if filled up with
13 Medicaid hygiene. I mean, you are just --
14 you are going to just lose money all day
15 long.

16 DR. BOBROWSKI: Yeah.

17 DR. SCHULER: And Joe is right. I mean,
18 you are going to have higher no-show rates.
19 It's not like -- you know, people think the
20 only folks that no-show are Medicaid
21 patients. I mean, I have been no-showed by
22 every population there is. You know, it
23 happens, but it is higher with Medicaid.
24 And, you know, if reimbursements were
25 higher, it would be less painful because

1 you would, you know, recoup it on the ones
2 that did show up. And you do have -- so I
3 mean, if you're having a 20 percent no-show
4 rate, you overbook by 20 percent, and like
5 Joe said, some days are real interesting,
6 but for the most part they are not. I
7 mean, you end up having kind of a regular
8 day, but you got to overbook and, you know,
9 patients are waiting forever for treatment.
10 It takes forever to get into oral surgeon's
11 office. And I mean, I appreciate, you
12 know, everybody who had a part in elevating
13 the oral surgery fees because it kept the
14 oral surgeons in the system. Now, how do
15 we keep the GPs in the system? Just look
16 at what we had to do to keep the oral
17 surgeons in the system, by bumping up these
18 oral surgery codes. Look at all the other
19 codes and that's what we are going to have
20 to do if we want to not only expand the
21 system, but if we want to keep the ones in
22 here. You know, as the economy gets
23 tighter and tighter, it gets harder and
24 harder. You know, compensation is up.
25 Supplies are up. Lab bills are up.

1 Everything is up. But, you know, if you
2 are seeing a large percentage of Medicaid
3 patients, you are just -- you are going in
4 the hole deeper and deeper every day and
5 that is a tough sell job for any provider
6 to, you know, hey, come join us and, you
7 know, you can lose a lot of money. That's
8 not really a good thing. I mean, even
9 with, you know, even with our cost
10 structure -- and I mean we have a lot of
11 offices. Even with our cost structure,
12 there's only so much Medicaid we can see.
13 I was really -- I hated to hear that, you
14 know, we are closing an office on 18th
15 street because that usually means our Dixie
16 Highway office is going to blow up with
17 Medicaid patients. You know, and that's
18 why I know there's such a poor network out
19 there. We can close new patients off at an
20 office. And I'll see an office 20 miles
21 away, 30 miles a way, that's where all
22 those patients are going. And what that
23 tells me is there's nobody in between
24 there, you know, seeing Medicaid, because
25 people don't want to drive any more than

1 they have to. So, I mean, we got a poor
2 system and this -- while this increase in
3 the oral surgery fees and some of the other
4 fees is helpful, it's a step in the right
5 direction. You know, we are not -- the
6 reason Indiana has got so many Medicaid
7 providers is because their reimbursement
8 rates are so much higher. You know, our
9 Indiana offices -- all of our Indiana
10 offices see Medicaid. And they don't
11 complain about Medicaid and, you know, they
12 don't even complain about the no-shows with
13 Medicaid. I mean, they have them and
14 nobody likes them. But the reimbursement
15 rates are so much higher than Kentucky, it
16 takes some of the edge off, you know, the
17 no-show issues and just some of the, you
18 know, the behavioral stuff and -- I mean,
19 you know, it's -- it's sometimes a
20 difficult population to take care of. But
21 it all comes down to fee schedules. I
22 mean, we can dance around it all day long,
23 but, you know, it is what it is.

24 DR. COLEMAN: Dr. Schuler, I agree with
25 you. It's all about the fee schedule. And

1 I know in Indiana, they say that's the
2 number one reason dentists don't take
3 Medicaid. But I will tell you that the
4 Dental Association is having a big problem.
5 In fact, I testified in front of the Ways
6 and Means Committee last night,
7 specifically on a bill that we are trying
8 to pass that would get the Medicaid dental
9 rates up to the 50 percentile of ADA. And
10 so -- and the legislatures get it. A lot
11 of them visit our offices and they are
12 hearing it from their constituent dentists
13 and they are hearing it from their
14 constituents who are patients, so -- but
15 you are right. I mean, we have to do
16 something in Kentucky. And the problem is,
17 in some states they can make changes
18 without legislation, just like Medicaid did
19 this time with the oral surgery stuff and
20 by covering this additional adult
21 population in a way that nobody knew they
22 could do. But when you say talk about make
23 a wholesale improvement in a way that's
24 going to be meaningful for like the general
25 population, that almost requires

1 legislative action. And the problem is, we
2 can only do that every two years. So I
3 think we are going to have to gear up this
4 summer in preparation for next year to try
5 to get the legislative leaders to buy into
6 it.

7 And this is the other thing -- and I
8 shared this with Dr. Bobrowski, in Virginia,
9 we were able to get a 30 percent across the
10 board rate increase last legislative
11 session. We had by partisan support for it
12 in legislature. And everybody was excited,
13 we thought it was going to make a big
14 difference. And for those of us who are
15 primarily Medicaid, yeah, it was helpful.
16 But, again, you are starting at a lower
17 base. And so that 30 percent -- I used this
18 example last night. You use a couple
19 swimming pools. But you got a swimming pool
20 that's 12 feet and a swimming pool that's
21 four feet, which is where we are in
22 Kentucky. You increase reimbursements
23 25 percent, you just go up to 5 feet. Where
24 as if you have a ten foot --
25 DR. BOBROWSKI: Yeah.

1 DR. COLEMAN: -- you know, and so it has to
2 be meaningful. And the longer they wait,
3 the harder it's going to get. So we're
4 going to have to ask for something
5 substantial. And I think the time to start
6 on it is this summer. Otherwise, it's just
7 going to feel completely deteriorate in the
8 next three years before the following
9 budget session.

10 DR. BOBROWSKI: Justin, I will call your
11 attention there to these -- just like these
12 adult -- they call them prophylaxis or a
13 cleaning codes. It's a D1110. And this
14 has just been up to -- you know, I know you
15 got your fee for service set rate, but some
16 of the MCOs take, you know, 10 percent off
17 of that fee. And the adult code pays
18 46.25, according to this new fee list.
19 Well, you know, Dr. Phil, I don't know what
20 you-all have to pay for a hygienist, but,
21 you know, it's anywhere from, oh, around 30
22 to \$35 an hour, you know, around our area,
23 give or take on that just a little, but
24 it -- you can see right there, you're
25 already almost starting off in the hole.

1 By the time you pay the hygienist and then
2 pay her social security and withholding --
3 not her withholdings, but her social
4 security taxes and stuff and -- of course,
5 we did get it allowed to clean, you know,
6 like once every six months, but the -- for
7 a lot of our adults, man, it -- you --
8 it's -- those a lot of times have patients
9 that haven't been to the dentist in years.
10 We have had two or three yesterday. You
11 can't even clean them in an hour. They
12 have got that much tartar and stuff. So I
13 mean, that adult fee -- I mean, the child
14 fee is \$60. Even if it was raised to the
15 child's fee helps, but those are fees
16 that -- you can't keep doing them. And
17 it's like Dr. Phil said a while ago, you
18 have paid a hygienist all day long and you
19 have gone in the hole --
20 MR. DEARINGER: Yes, sir. This is Justin
21 Dearing. And I -- like I said, I
22 encourage you-all to put together a list of
23 fees that you think, you know, could be
24 incorrect, that are too low to -- you know,
25 you-all are having a hard time actually

1 doing the services because they are so low,
2 and then send me that on an e-mail, because
3 it takes time for us to research that. I
4 know we had a discussion before we created
5 this fee schedule and we looked at the top
6 ten fees that were billed by dentists. And
7 we looked at every state that touched the
8 state of Kentucky. And the state of
9 Kentucky was higher than the average for
10 each of those states, for those ten codes.
11 So we know those codes in particular, you
12 know, there's no pricing or fee schedule
13 issue with, but you look -- that's a large
14 fee schedule. So I'm sure there are codes
15 on there that need some help. But in order
16 to do that, we have to make sure we do the
17 research. We have to do the research on
18 our end to see what every other state's
19 paying, to see what private insurance is
20 paying. And so we have to put all that
21 work in and then we have to run that
22 through the budget to see if we can get the
23 codes. I know you-all know that we
24 attempted to move all of the child fees and
25 adult fees to be the same. That was not in

1 our budget. We were unable to do that
2 budgetarily. So I think, like somebody
3 said earlier, that is something that is
4 taking up and fixed by legislation, because
5 we don't have that kind of money in the fee
6 schedule -- or in our budget to be able to
7 make those kind of changes to the fee
8 schedule. I know there are a lot of
9 providers that have a gotten no change in
10 their fee schedule this year at all, no
11 increases, and we were able to increase as
12 many things as we could for this 2023 fee
13 schedule.

14 But, you know, one of the things that
15 we make sure that we do is, if you find a
16 code that you feel like this is -- you know,
17 I can't do this procedure because this code
18 is too low and, you know, we can't afford to
19 do it, make sure to include that in the list
20 that you send me and we will make sure to
21 research that according to other states and,
22 again, private insurance pay.

23 DR. BOBROWSKI: There's another code there
24 that -- it's a new code. It's a -- and I
25 know you-all have done this research,

1 but -- and I don't have to do this code
2 very often, but it's the D5621 and D5622,
3 but it says to repair a cast partial frame,
4 which is the metal, the metal work of a
5 partial denture to -- my -- the last one I
6 sent for repair, the lab bill was like \$98.
7 And, I mean, and you are going to pay
8 72.60. See, that's what I mean. It
9 doesn't even cover our lab bill to repair
10 one of those, so, I mean, those -- I know
11 you said you done your research, but -- and
12 even when we use our lab -- I mean, we
13 don't necessarily try to find the cheapest
14 lab, but we try to find labs that are
15 reasonable and -- but the main criteria is
16 when we use a lab is that, they do good
17 work. You don't have to refit. We don't
18 have to redo things. You want that partial
19 to fit perfect. Now -- but anyway, that's
20 just another one of those codes that we
21 might need to look at.

22 All right, TAC Members. Let's get
23 our -- if you-all want to look at those --
24 that fee list and, you know, maybe just send
25 them to me or send them -- we can either do

1 one list or send them individually. Might
2 be better to do one list of the codes and
3 maybe possible revisions that we need to
4 look at and then we can get that to them
5 here ASAP and get to going on this.

6 Now, is there any other old business?

7 (No response).

8 DR. BOBROWSKI: Okay. The new business, I
9 got the MLR stands for Medical Loss Ratio.
10 And -- and some of these we can put on here
11 just for, you know, helping us learn your
12 acronyms and stuff, but right now, the
13 MCOs -- and correct me if I'm wrong, but I
14 think it's a 90 percent of the capitation
15 monies that you receive go towards patient
16 care.

17 And then the next question I had down
18 is, who's exactly in charge of the MCO
19 dental contracts? And I'll have to pose
20 that question to someone from the state,
21 please, or at MCO.

22 MS. SHEETS: Angie, are you still on?

23 MR. DEROSSETT: This is Jeremy --

24 MS. PARKER: Yes. Jeremy can answer.

25 MR. DEROSSETT: This is Jeremy Armstrong

1 DeRossett. I am the branch manager of the
2 contract monitoring branch that oversees
3 the state MCO contracts. And so I would
4 be, for the state side, the person who
5 oversees and in charge in a sense, but if
6 any of the MCOs dental contracts that they
7 have with any of their subcontractors, that
8 responsibility would still be on the MCOs.

9 DR. BOBROWSKI: But now you -- your
10 division -- I mean, like who drafts the
11 language for those contracts? Is that your
12 division?

13 MR. DEROSSETT: Yes, sir.

14 DR. BOBROWSKI: Okay.

15 MS. PARKER: Not for the dental
16 contractors. This is Angie Parker with
17 Medicaid. The dental contracts are
18 subcontracts of the MCO and they are the
19 ones who develop the language in the
20 subcontract.

21 DR. BOBROWSKI: Okay.

22 MS. PARKER: The MCOs directly contract
23 with the dentist -- the dental -- Avesis,
24 that's through them, but we do monitor
25 their subcontracts as well.

1 DR. COLEMAN: From my standpoint, I think
2 the reason for asking this question is --
3 might not be for Dr. Bobrowski, but the
4 problem we have is that the MCOs are taking
5 money off of the exceedingly low fee for
6 service schedule. And I know that happens
7 in some other states, but it doesn't happen
8 in other states. I go back to what
9 Dr. Schuler said about Indiana, about maybe
10 people not complaining as much. They
11 haven't increased rates there in a long,
12 long time either, but their MCOs don't take
13 money off the top of what the state sets as
14 the fee schedule. Now, I know United
15 Healthcare doesn't do that, which is
16 helpful in Kentucky, but others do. And
17 it's -- over the years, it's been
18 significant. Let's just put it that way.
19 And, I mean, it would be one thing if we
20 were all getting paid at all like usual and
21 customary. But when you are like 150 to
22 200 percent below usual and customary, and
23 then somebody takes an additional however
24 much off, that's not good. And the reason
25 this is important is because, in your

1 contracts with the MCOs in the future, it
2 might be a good idea to require
3 reimbursement, at least, at the state fee
4 schedule, as they do in Indiana. That way,
5 if we do legislative activism and we have
6 money put towards the dental program to get
7 rate up like we did in Virginia, some money
8 would go straight through to the providers.
9 In fact, in Texas right now, they put
10 language in the budget as they are trying
11 to increase rates so that the money will do
12 exactly that. So that's -- I'm glad you
13 raised this question, Dr. Bobrowski.

14 DR. BOBROWSKI: Well, it's just -- it's one
15 of those things that, you know, we've just
16 got to look at getting our providers back.
17 And I know the MCOs do a lot of great work
18 for us, but, you know, we have all got to
19 get in on this together or I'm just afraid
20 this -- I'm going to age out here one of
21 these days. I still got 25 or 30 good
22 years left in me, I believe, but -- that's
23 a joke, Phil. It -- but, you know, we like
24 to try to help people as long as we can.
25 But we will work on that one. But I know

1 Dr. -- Senator Alvarado did have a bill
2 that was going to be presented this year
3 and may have to work on it this summer
4 again to -- you know, to have the MCOs pay
5 at the fee for service rate as a minimum,
6 but...

7 All right. Any other questions on
8 that or comments?

9 MS. LOCKE: Yeah, this is Loren, again, for
10 DentaQuest for Anthem. I was just going to
11 add that we are currently paying at or
12 above the current fee schedule and that
13 went into effect -- we backdated it to
14 1/1 -- well, we always have. But for the
15 new fees, they were updated and we
16 reprocessed all of those for 2023.

17 DR. COLEMAN: Thank you. That's great.

18 DR. BOBROWSKI: Thank you. All right.

19 Now, on this next item is reports --
20 the report requests for the state and the
21 MCOs. I know we've been kind of working on
22 this. And if we've got anything to -- and
23 that we can include this, what to go into
24 the report to go to the MAC, you know, on
25 some of these requests, but -- I know in the

1 past we used to get a multi-page document
2 from each MCO and had all kinds of reports
3 in those. And there's one that has been
4 particular of interest is the development of
5 the -- I guess, you-all correct me if I'm
6 not using the correct term, but I think they
7 were called the GEO maps, and kind of
8 coordinating that with a claims paid sheet.
9 And then it may actually be required to
10 have -- in that report, more than one sheet.
11 But I'm not a statistician. I don't do a
12 lot of graphs and things like that and
13 charts, but you-all can do this. But one of
14 the things I was looking at was to do a GEO
15 map of the -- across the state of the
16 numbers or the providers that are doing
17 anywhere from \$1 to \$1,000. And I put down
18 here just in my thoughts was, like \$1 to
19 \$1,000 per quarter; \$1,001 -- another page
20 of \$1,001 to \$3,000 per quarter; \$3,001 to
21 \$5,000 per quarter; \$5,001 to \$10,000 per
22 quarter; and \$10,001 on up per quarter. I
23 didn't know if -- I picked quarter, we could
24 change it to monthly, but I think in the
25 past we have gotten something like that

1 to -- and by using the GEO maps, I think
2 that kind of helps to see where there are
3 shortage areas in the state. Any discussion
4 from TAC members?

5 DR. SCHULER: Well, I think you've got --
6 you know, you kind of got -- the state is,
7 you know, tasked with taking care of its
8 people. So there is a need to have an
9 adequate provider network. The MCOs are
10 mandated to have a certain amount of
11 coverage in the state. So -- I think it's
12 provider of 50-mile radius or something
13 like that. I think there is an urban and
14 suburban limitation. So, I mean, the state
15 would gather based on reimbursements, like
16 you said -- because there's a big
17 difference between somebody being a
18 Medicaid provider, you know, and seeing,
19 you know, a couple patients a week, as
20 opposed to somebody who's Medicaid provider
21 and they are seeing 20 or 30 patients a
22 day. I mean, that's a huge difference.
23 And either one of those count as a provider
24 in the network, but they are not the same
25 level of provider. And we know that. So,

1 you know, if you've got a bunch of -- if
2 you've got a bunch of, you know, providers
3 that are barely doing any dentistry -- I
4 mean, we need them. I mean, thank goodness
5 for them. But that doesn't really show the
6 picture. So you know, if you had some sort
7 of cutoff where -- where you just kind of
8 in your own mind think, okay, somebody's
9 doing, you know, 10 to 15,000 bucks, you
10 know, a quarter in Medicaid, they are maybe
11 putting a dent in it a little bit, you
12 know, I'd like to see that map compared to
13 just anybody who is a Medicaid provider. I
14 mean, a lot of our offices, a whole heck of
15 a lot more than 10 or 15,000 bucks a
16 quarter. It's a month, and some of them,
17 probably a week.

18 DR. BOBROWSKI: Yeah.

19 DR. SCHULER: But still, you know, it would
20 be nice to see that correlated to
21 reimbursement levels.

22 DR. BOBROWSKI: Would you rather see this
23 on a monthly basis instead of a quarter
24 basis?

25 DR. SCHULER: Well, I think quarterly is

1 fine. I mean, we don't need to get too
2 granular with it, but --
3 DR. BOBROWSKI: Right.
4 DR. SCHULER: -- I think quarterly --
5 quarterly would certainly paint as clear a
6 picture as monthly. And, I mean, you could
7 even do it on a trailing 12-month -- you
8 know, rolling 12-month basis so you'd
9 catch any -- I mean, if we got that report
10 quarterly, you know, on a rolling 12-month,
11 you know, that would probably do it.
12 DR. PETREY: Garth, yeah, we will want to
13 break this down as well by GP and then by
14 the specialties, too --
15 DR. SCHULER: Yeah, yeah, yeah.
16 DR. PETREY: -- I mean, to make sure that's
17 in there.
18 DR. BOBROWSKI: Okay. Sure.
19 DR. SCHULER: Yeah.
20 DR. PETREY: Because that's what's really
21 going to scare you, when you see the
22 specialty. I think we've got the only --
23 there can't be hardly anybody else seeing
24 pediatric patients in Louisville Metro,
25 pediatrician -- ped-odontic, you know,

1 providers. There's a lot of people seeing
2 kids, but, you know, they are not -- you
3 know, they are not pedodontists.

4 DR. BOBROWSKI: There was another office
5 close by me that was a Medicaid office. It
6 was a younger guy even and -- but he just
7 recently dropped seeing all adults, so that
8 throws them -- I mean, I don't mean this a
9 in a bad way, but that pushes them over
10 here to me. And I don't mind, but the --
11 and then another office west of here, they
12 are -- they are down to -- oh, and the
13 one -- did I say that he -- he just -- he
14 dropped all adult. He's only seeing
15 children now. And then another office west
16 of here, they have got another office in
17 another town. They do not see any Medicaid
18 there in that town. The only -- one
19 office, they -- they're down to only seeing
20 children, too.

21 DR. SCHULER: Some of the state can
22 actually do any -- you know, any of that
23 work. I mean, I know it's -- I mean, it's
24 somewhat labor intensive, you know, to come
25 up with that, but --

1 DR. BOBROWSKI: What I'll have to do --
2 DR. SCHULER: -- it will be helpful.
3 DR. BOBROWSKI: Yeah. Some of these, we
4 can ask through the Commissioner's office
5 to see if this would need to go to them or
6 do it by MCO. And if we go through the
7 state, they may be only able to give us
8 information from the fee for service part
9 of it, where if we really need to get that
10 report from the MCOs to see what they cover
11 in their territories. So did somebody want
12 to the ask something else?
13 DR. COLEMAN: I was just going to say, you
14 might see what the dental benefit
15 administrators have to say. I know in
16 Virginia, DentaQuest actually pulls that
17 information and shares it with Medicaid and
18 certain people in the community. So I
19 don't know, maybe Dr. Caudill or somebody
20 could speak to that. If not, I mean, I've
21 found that sometimes you are better off
22 just going to a legislator and having them
23 request the information. And then
24 generally, everybody jumps in line and they
25 get it for them, especially if it's a

1 legislative leader.

2 MS. ALLEN: Hello, Dr. Bobrowski. This is
3 Nicole with Avesis. We would be more than
4 happy to provide that information, but we
5 will have to receive the direction from DMS
6 if they give us the authorization to do
7 that. As I understand, the reporting
8 requests go through DMS. But if you, you
9 know, would like us to provide that level
10 of information, we do have availability to
11 provide that. Or I should say capabilities
12 to provide that.

13 DR. BOBROWSKI: Great. Thank you,
14 Ms. Nicole. Appreciate that.

15 MS. SHEETS: Dr. Bobrowski, this is Kelli
16 Sheets, again.

17 DR. BOBROWSKI: YEAH.

18 MS. SHEETS: If you would e-mail us and let
19 us know exactly what you want in writing in
20 a report, we can send that on for you.

21 DR. BOBROWSKI: Okay. Thank you.

22 Now, and like I said at the start of
23 this, I'm not one to develop graphs and
24 charts and stuff. I know you all in the
25 past have done those GEO maps and can maybe

1 include, you know, methods to put the
2 numbers with that, that -- you know, those
3 amounts of claims paid. It would probably
4 be helpful if we came up with kind of the
5 same type of design. So that way, the
6 reporting matches each other pretty close.
7 And Ms. Kelli, I'll e-mail you about that
8 one. And then we will get that one on
9 the -- on the road here.

10 MS. SHEETS: Okay. Sounds good. Thank
11 you.

12 DR. BOBROWSKI: Thank you.

13 DR. PETREY: Yeah, Dr. -- let's -- let's
14 work on -- let's work on that. But, also,
15 I'd like to -- if feasible, I would like to
16 see if that can be at our next meeting,
17 that we have that prior to, so we can
18 review it and then be able to discuss that
19 at our next meeting.

20 DR. BOBROWSKI: I'll make a note there.
21 Okay. We will get that one done. You
22 know, when I've gone to some of those MAC
23 meetings, you know, we have received, you
24 know, some support from other health care
25 providers. And I don't -- I don't know

1 that this has to be any kind of a
2 resolution or vote on or anything, but we
3 can if we want to, just -- I think it's
4 good to, you know, the Dental TAC, you
5 know, work with other health care
6 providers. You know, we are all in this
7 together on -- and even healthcare
8 providers to continue to deal with our and
9 work with our straight state administrators
10 and lawmakers and each other, you know,
11 to -- it's all about taking care of
12 patients, is our number one goal. And
13 sometimes, we've got to figure out the fine
14 details of getting patients seen, but we
15 just got to work together on that. Like I
16 said, we are all in this together.

17 And then here's another item that --
18 you know, TAC Members, we can all encourage
19 our own dental office administrators or our
20 office managers and our staff, you know, for
21 their input on policies and getting this
22 care delivered, you know, to our patients.
23 So that might be just something to -- and
24 I'm sure you-all do, too. I know I try to
25 listen to my office folks, because they

1 handle the paperwork. They see what works,
2 what doesn't work and what we might need to
3 tweak.

4 But here's another possible report --
5 let me make a note here -- is to maybe get a
6 report from the MCOs on a list of the prior
7 authorization codes -- or the codes that
8 require a prior authorization and the
9 percentage of denials compared to the
10 percentage of approvals. And it may be
11 interesting, too, to find out, well, what is
12 the reason of the denials. And I know
13 sometimes it's just, well, maybe an X-ray
14 got sent in that maybe wasn't readable or
15 wasn't -- or was the wrong tooth. You know,
16 I know when I send in things, I try to tell
17 my front office people exactly which picture
18 to send in, but sometimes -- I'm not sure,
19 sometimes -- and I don't have -- personally
20 I don't have much trouble with any of that,
21 but I'm not saying that they couldn't -- by
22 the time of the phone rings and they are
23 checking somebody in or checking somebody
24 out that they will say, which -- now which
25 tooth was it I got to send? Or the X-ray

1 and which -- I think it was this one and
2 they punch the send, but I can see where
3 that sometimes can happen. But I don't
4 know. Is that a -- an informative piece
5 that any of the TAC Members would be
6 interested in or are we okay with that one?

7 DR. CAUDILL: Garth, if I can point out one
8 thing.

9 DR. BOBROWSKI: Okay.

10 DR. CAUDILL: As you know, you know,
11 there's clinical criteria out from the
12 various MCOs and their TPAs.

13 DR. BOBROWSKI: Right.

14 DR. CAUDILL: And quite often, a doctor
15 will know that a prior authorization will
16 not be approved. But in order to then
17 offer a payment plan, or there was an aunt
18 or an uncle willing to pay for that
19 treatment, even though it doesn't qualify
20 under Medicaid criteria, they still need
21 denial in writing from us before they are
22 allowed to do that. Orthodontics is a very
23 good example of that, where, you know, the
24 orthodontics will check no to every single
25 box saying, I know this case does not meet

1 medical necessity as outlined in the KAR
2 regulations. However, it's more of a
3 cosmetic issue and maybe there's a
4 grandmother that's willing to pay for this,
5 but I can't bill them until I get that
6 denies from you. So those kinds of things
7 can actually skew the number of denials,
8 just because they are sending in, knowing
9 they don't need criteria.

10 DR. BOBROWSKI: Okay. That's a good point.
11 I know -- you know, I've got that list of
12 criteria for orthodontics close by here
13 and -- and I'll -- sometimes I'll do that.
14 I'll just tell the parents or grandparents,
15 I'll say, from what I can see, I don't
16 believe you are going to get this approved,
17 you know, because they just -- you know,
18 it's just a couple of -- you know, a couple
19 of rotated maxillary interiors and that
20 doesn't hardly meet any of the criteria.
21 But like you said, that's a good point
22 Dr. Caudill, that they might just want that
23 denial, but I try to -- and if they insist,
24 well, I will give them a referral to an
25 orthodontist, but I'll -- I don't know what

1 else to do. You know, just let them get
2 the denial and -- but does any TAC
3 Member --
4 DR. SCHULER: Garth?
5 DR. BOBROWSKI: -- do we need anything else
6 on that one or we can let it go or -- go
7 ahead.
8 DR. SCHULER: Garth, I think I'd rather
9 focus on the -- let's get some data wrapped
10 around the provider network, and, you know,
11 let's focus on that and, you know, see
12 where we are at there --
13 DR. BOBROWSKI: Okay.
14 DR. SCHULER: -- as opposed to kind of
15 layering this on top of it.
16 DR. BOBROWSKI: Okay. Here's another
17 question that might go with that then,
18 Dr. Phil. It's just like, well, how many
19 dental providers are in the fee for service
20 network? How many are in each MCO? Would
21 that be of any benefit?
22 DR. SCHULER: We can usually pull the data
23 by reimbursement levels internally. I'm
24 not sure if that would help understanding
25 the full network, unless there were gaps.

1 If we are getting reports from each MCO,
2 then, you know, we will be able to --
3 basically each MCOs network. I think that
4 might be give us similar information.
5 DR. BOBROWSKI: Okay. Now, here's another
6 question that might go in with that, the
7 GEO maps one, was, would it be helpful to
8 have a map or chart showing where the
9 Medicaid population is in relation to the
10 number of providers for Medicaid?
11 DR. SCHULER: When getting an address on
12 these people?
13 DR. BOBROWSKI: No, no, no. I'm just
14 going -- just --
15 DR. SCHULER: That's going to be tough.
16 DR. BOBROWSKI: Like I say, I'm not a
17 statistician, so I -- these are just some
18 questions that I've had posed -- some of
19 these are just things I've had posed to me
20 and --
21 DR. SCHULER: Well, I think if you -- I
22 think if you have a pretty clear picture of
23 the provider network -- because we know
24 people are driving hours, you know, to be
25 seen.

1 DR. BOBROWSKI: Yeah, yeah.

2 DR. SCHULER: I mean, that's -- we hear

3 that over and over again, especially from,

4 you know, a lot of our specialists,

5 especially the oral surgeons. You know, I

6 think if we had -- I think if there's more

7 information that we want to kind of layer

8 on top of the initial data, I think that we

9 can ask better questions once we know a

10 little bit more.

11 DR. BOBROWSKI: Okay.

12 DR. SCHULER: Just my thought.

13 DR. BOBROWSKI: That's great. Here's

14 another thing. And I know -- and I think

15 it was DentaQuest, last meeting mentioned

16 some work they were doing -- and again, I

17 think this is stuff we need to work with

18 each MCO and the Commissioner, the MCOs, to

19 decrease the emergency room visits. Last

20 year there was over nine million dollars

21 the state had to spend on dental related ER

22 visits. And I just wanted to put that out

23 there that, you know, that's a big chunk of

24 change. And I told the Commissioner once

25 there that, you know, I had a patient from

1 another county, you know, a smoker that
2 didn't follow our directions and developed
3 a dry socket. You know, we treated it, you
4 know, once here and we said, well, come
5 back tomorrow and we will treat this again,
6 if it's needed. Well, she didn't show up
7 the next day. And then she came back later
8 for another appointment a week or two
9 later, but we asked, well, did that get
10 better or what happened? And -- we didn't
11 see you the next day. She said, oh, I just
12 went to the emergency room and had them
13 treat it. You know, now, the emergency
14 rooms, I don't know exactly what the charge
15 is, that they charge the MCO or they charge
16 the state, but I think it's hundreds of
17 dollars per visit. And I told the
18 Commissioner I said, well, typically, you
19 know, if somebody's got a dry socket, we
20 normally don't charge for that. You know,
21 and -- I mean, but whereas if they go to
22 the emergency room, that's -- it's usually
23 several hundred dollars. So I think we
24 need to work with our MCOs and the
25 Commissioner on seeing what can be done to

1 decrease these emergency room -- of course,
2 a lot of times, it's, you know -- from what
3 I see, it's patients either won't go or
4 can't go -- for a number of reasons, they
5 won't go to the dentist. Because I know
6 none of the emergency rooms around here do
7 fillings. Don't see very many emergency
8 rooms that pull teeth. So they kind of
9 doctor them up, you know, 'til -- they say,
10 well, you go see a dentist tomorrow, so --
11 but I would kind of think we all just need
12 to work together on decreasing the
13 emergency room visits. I don't have any
14 ideas to give you today, but is that
15 something we want to talk any more about
16 today or I can move on?

17 DR. SCHULER: Well, I think a lot of that
18 would help by having a more robust provider
19 network.

20 DR. BOBROWSKI: Yeah, yeah.

21 DR. SCHULER: I mean, the fact that
22 somebody would sit six or eight hours in an
23 emergency room to get something looked at,
24 you are not going to get treated, just get
25 it looked at, as opposed to going to a

1 dental office is crazy. I mean, I can't
2 imagine how the ER would be your top choice
3 unless you knew you were going to get, you
4 know, six or eight, you know, Hydrocodone
5 to get you through, so...
6 DR. BOBROWSKI: Right. Yeah.
7 DR. SCHULER: And from the Commissioner's
8 annual report put out, what this state
9 spends on opioids could quadruple, you
10 know, what -- ten times what we get
11 reimbursed for dental care. It's
12 incredible what we spend on opioids in this
13 state. And they don't even get treatment,
14 so, no, I think that kind of goes back to
15 data collection from the MC0s and the state
16 as far as provider network. We need a
17 better provider network. You are going
18 to -- drop.
19 (Zoom audio problem).
20 DR. BOBROWSKI: On that one --
21 MS. ALLEN: Dr. Bobrowski?
22 DR. BOBROWSKI: Yes, go ahead.
23 MS. ALLEN: I'm sorry. This is Nicole
24 again with Avesis. We do offer an
25 emergency department innovative program

1 that we are currently administering with
2 some of our MCOs and have seen significant
3 results in the decrease of patients re --
4 are going to the emergency department
5 multiple times. So just as an FYI, we are
6 looking at -- kind of outside the box to
7 identify ways to encourage members to stay
8 with their dentists, utilize Telehealth
9 services, as opposed to utilizing the
10 emergency department.

11 DR. BOBROWSKI: Great. Okay. Thank you.
12 I've got -- of course, more and more this
13 last year than even this year, I've got
14 more and more patients that will -- on -- I
15 guess it's Facebook Messenger. They will
16 send me messages about this or about that.
17 And, of course, I've heard some dentists
18 saying that they will tell their patients,
19 don't do that, but sometimes folks that
20 they have gotten rid of their home phones
21 and a lot of home phones are not in any
22 phone books any more. But I know at our
23 office here, we try to leave a phone number
24 that -- and a lot of offices do, too, just
25 an after-hours contact phone number, so --

1 but the last question I've got is -- this
2 was asked by another physician's group or
3 something. On pregnant ladies and oral
4 healthcare, I -- in my mind, I didn't think
5 there was any way using our codes to see
6 if -- you know, how many of the pregnant
7 ladies were -- like for instance, getting
8 an exam and cleaning. Because I think
9 the -- most of the time, we just use our
10 regular exam and pro fee codes. Be don't
11 differentiate whether they are, you know,
12 pregnant or not. But this was just a
13 question asked and -- about, you know,
14 pregnant moms and oral healthcare. Anybody
15 got any ideas on that or just -- I don't --
16 I couldn't think of any way to really, you
17 know, develop any kind of report on that
18 one. All right. I'm going to move on
19 here.

20 MR. OWEN: Dr. Bobrowski, it might be a
21 little dangerous for me to guess here, but
22 is there perhaps an ICD 10 code that would
23 show pregnancy? I don't know. That's just
24 a thought.

25 MS. O'BRIEN: Yeah, I think so, Stuart. I

1 was thinking the same thing and looking to
2 see if they had a -- you know, identify
3 those members and then see if they have had
4 a dental visit.
5 MR. OWEN:
6 MS. O'BRIEN: Probably is a way to do that,
7 yeah.
8 DR. BOBROWSKI: Yeah, you would have to
9 look at the ICD 10 codes --
10 MS. O'BRIEN: Uh-huh (affirmative), uh-huh
11 (affirmative).
12 DR. BOBROWSKI: -- to see pregnancy status.
13 MS. O'BRIEN: Correct.
14 DR. BOBROWSKI: Then use that patient name
15 or that number and then go to the dental
16 record.
17 MS. O'BRIEN: Right.
18 DR. BOBROWSKI: That's a lot of work --
19 that's a lot of work -- I don't know --
20 MS. O'BRIEN: Well, I think --
21 DR. BOBROWSKI: -- I'm just trying to.
22 DR. BRAUN: Yeah, it would have to be more
23 at the MCO level instead of it being at the
24 sub -- you know, not the subcontractor. It
25 would have to be like Anthem and WellCare

1 and Molina and --
2 DR. BOBROWSKI: Right.
3 MS. O'BRIEN: -- to be able to pull that
4 data together.
5 DR. BOBROWSKI: Is that something that
6 would help us on any kind of treatment
7 planning or -- I mean, the -- the -- to be
8 honest, the pregnant ladies that come to
9 our office, we don't see a lot of -- I
10 mean, yeah, every now and then, we might
11 have to pull a tooth or do some fillings,
12 but I really don't see anything different
13 than any other patient.
14 DR. BRAUN: Right.
15 DR. CAUDILL: I think that stipulation was
16 removed in the new iteration of the KAR.
17 MS. O'BRIEN: Uh-huh (affirmative).
18 DR. BOBROWSKI: Okay. Let's move on, on
19 that one there. Are there any other
20 reports that the TAC Members would move on
21 to the MAC? I believe the main thing is
22 just developing our -- what we first talked
23 about on that. And then I can get that to
24 Ms. Kelli. And then I believe our folks
25 there can work on that one. I'm not seeing

1 anything that we need to report to the MAC,
2 unless you-all have got something else.

3 All right. I'm going to move on real
4 quick to -- usually in the past, I would --
5 you know, we would have election of the
6 chair and vice chair for the TAC at the
7 first meeting of the year. Now, I was
8 researching that with one of our helpers
9 there from Frankfort. And they were talking
10 about, well, maybe through the MAC
11 regulations that's done through the first
12 meeting of the fiscal year, you know, which
13 would put that up in the summer. Now, we
14 could have -- we could do -- by that, we
15 could have nominations made, you know,
16 either like at our meeting today or at our
17 meeting in May. And then our meeting
18 there -- August meeting, we would have our
19 vote. But we do have to probably have the
20 nominations, you know, maybe a meeting
21 before, and then that would be put on the
22 next agenda to actually vote on. That's
23 just kind of what I was going by on the MAC
24 rules.

25 MS. BICKERS: Dr. Bobrowski, this is Erin

1 with DMS.

2 DR. BOBROWSKI: Yes.

3 MS. BICKERS: We ask -- like to make your
4 recommendations or the nominations in this
5 meeting. And I would think your May
6 meeting would be close enough to the fiscal
7 year that you guys can make your vote on
8 that, so you don't have to wait until
9 August.

10 DR. BOBROWSKI: Okay.

11 MS. BICKERS: But that's completely up to
12 the TAC.

13 DR. BOBROWSKI: Okay. Well, let's get our
14 nominations in and then we will -- we can
15 do our vote in May. We are just kind of
16 going by the rules of what are stipulated
17 in the MAC rules, but let's have the
18 nominations in for the chair and
19 nominations for the vice chair for the TAC.
20 And the floor is opened.

21 DR. PETREY: If you do it again, I nominate
22 you would be the chair.

23 DR. BOBROWSKI: Okay.

24 DR. SCHULER: Me too.

25 DR. PETREY: You said you number two, Phil?

1 You -- vice chair, is that what you were
2 saying?

3 DR. SCHULER: No, I said me too on Garth as
4 the chair. I mean, I'd be vice chair. I
5 don't care.

6 DR. BOBROWSKI: Okay. Well, we've got
7 nominations --

8 DR. SCHULER: Me and Garth talk often
9 enough any way.

10 DR. BOBROWSKI: Yeah. We could -- is there
11 any other nominations?

12 (No response).

13 DR. BOBROWSKI: All right. Hearing none,
14 we'll just vote on both at the same time
15 for me being the chair and for Phil being
16 the vice chair. And then we will -- well,
17 I guess we will have to just have those
18 nominations and actually vote on it in May,
19 but...

20 DR. PETREY: Yes.

21 DR. BOBROWSKI: We will vote. I guess
22 everybody in favor aye, we will just put
23 those two names on the ballot then in May.

24 DR. PETREY: Aye.

25 DR. BRAUN: Aye.

1 (All voted Aye) .

2 DR. BOBROWSKI: All right. Thank you-all.

3 Now, is there -- the one thing that's

4 very important that I do not want to leave

5 off today is we want to wish Ms. Erin the

6 very best, because she's getting ready to go

7 on maternity leave.

8 MS. BICKERS: Thank you, Dr. Bobrowski.

9 DR. BOBROWSKI: So we --

10 MS. BICKERS: 24 days.

11 DR. BOBROWSKI: Oh, boy. Well, we truly do

12 want to wish you the best and -- is it a

13 boy or girl?

14 MS. BICKERS: It's a boy.

15 DR. BOBROWSKI: Okay. Well, I've got --

16 MS. BICKERS: I appreciate that. Thank

17 you.

18 DR. BOBROWSKI: Yes. Is there any other

19 new business that we need to bring up?

20 DR. SCHULER: I know we have had a spot at

21 the end for any public comment. I looked

22 on the participant sheet. I couldn't tell

23 if there was any private dentists out

24 there, but we probably leave a little gap

25 at the end to -- you know, if any private

1 dentists or any other providers are on the
2 call, if they have anything that they'd
3 like to say to the TAC.

4 DR. BOBROWSKI: The floor is open now
5 for -- if anybody on the call list would
6 like to make a comment or have an
7 opportunity to make the recommendation or
8 for something for the TAC to look into or
9 whoever.

10 DR. SCHULER: Doesn't sound like we got any
11 takers, but just wanted to throw it out
12 there.

13 DR. BOBROWSKI: Yes. Thank you. Well, A
14 lot of times, if you will notice on the
15 agendas, I will try to put on there
16 either -- like you said, public comments or
17 other comments or other, especially like in
18 old business, just so I don't forget
19 something. And I did today. I forgot to
20 put on there about approving the minutes.
21 And then I swear, inevitably, if that --
22 I'll try to get the agenda out at least --
23 I try to do for two weeks, but the last two
24 it's been a week. But, inevitably, there's
25 always been something that will come up

1 that's like, oh, man, we need to talk about
2 that. You know, we can't really wait
3 another three months on that. So that's
4 why I put that other on there, is just to
5 kind of help speed up the process on
6 things, but...

7 Our next meeting will be May the 12th,
8 2:00 Eastern Time.and I really appreciate
9 everybody's input and thoughts and comments.
10 All we can do is just kind of keep working
11 together and try to do what we can to help
12 our patients and then we -- just to work on
13 our provider network. I think it's
14 critical, because we work on our provider
15 network, it really helps our patients. But
16 that's all I've got. Thanks everybody.
17 Hope everybody has a good weekend. And do
18 not forget that next Tuesday is Valentine's
19 Day. Treat your Valentine extra special.
20 DR. SCHULER: Most important holiday of the
21 year.

22 DR. BOBROWSKI: That's right. Well, thanks
23 everyone.

24 * * * * *

25 THEREUPON, the Meeting was concluded.

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STATE OF KENTUCKY)
COUNTY OF FAYETTE)

I, JOLINDA S. TODD, Registered
Professional Reporter and Notary Public in and for
the State of Kentucky at Large, certify that this
transcript is a true and accurate record of the
Dental Technical Advisory Committee meeting.

My commission expires: August 24, 2023.

IN TESTIMONY WHEREOF, I have hereunto set
my hand and seal of office on this the 4th day of
April 2023.

JOLINDA S. TODD, RPR, CCR(KY)
NOTARY PUBLIC, STATE AT LARGE

DR. BOBROWSKI: [150]	'	16/24 17/21 18/4 19/21 25/8 25/10 26/9
DR. BRAUN: [5] 18/10 18/23 91/22 92/14	'til [1] 87/9	26/11 27/8 29/1 30/2 30/6 30/13 30/17
95/25	1	33/6 33/14 33/18 33/19 33/23 38/14 46/10
DR. CAUDILL: [20] 19/3 19/5 20/20	1/1 [1] 70/14	46/10 47/9 48/11 49/6 49/8 49/15 50/18
36/18 36/20 36/23 37/6 37/8 37/17 37/21	10 [7] 1/15 46/12 52/21 73/9 73/15 90/22	58/11 58/12 58/25 59/22 68/9 68/9 78/7
39/10 39/18 40/4 40/13 41/17 41/21 81/7	91/9	79/11 87/15 89/16 89/16 90/13 92/23
81/10 81/14 92/15	10 percent [1] 61/16	93/10 97/20 98/1
DR. COLEMAN: [10] 47/3 47/5 47/20	101.40 [1] 32/24	above [1] 70/12
48/15 49/21 58/24 61/1 68/1 70/17 76/13	12 [3] 17/14 18/24 20/18	abscesses [1] 6/25
DR. PETREY: [16] 12/24 13/5 50/12	12 feet [1] 60/20	absolutely [7] 25/6 25/6 27/20 28/13
50/15 50/17 51/19 52/14 53/11 74/12	12-month [3] 74/7 74/8 74/10	29/25 42/8 53/18
74/16 74/20 78/13 94/21 94/25 95/20	120 [1] 20/22	accept [3] 13/2 52/20 53/4
95/24	12th [1] 98/7	access [1] 11/16
DR. RICH: [6] 20/4 20/7 38/7 40/19	130 [1] 33/17	accidentally [2] 29/8 42/11
40/24 41/2	15,000 [2] 73/9 73/15	according [2] 61/18 64/21
DR. SCHULER: [71] 3/24 12/25 15/20	150 [1] 68/21	accurate [1] 100/9
15/24 16/18 16/23 17/6 17/17 17/19 18/6	18 [2] 48/2 52/9	achieve [2] 51/7 51/8
18/17 19/10 19/12 19/18 20/6 20/10 22/6	18th [1] 57/14	acknowledge [1] 54/12
22/9 23/7 23/23 24/13 33/10 33/12 34/2	1:00 [1] 44/5	acronyms [1] 66/12
34/18 34/24 35/8 38/11 38/13 38/17 39/21	2	across [4] 45/23 46/19 60/9 71/15
40/9 40/16 41/1 41/13 41/20 42/19 42/24	20 [2] 50/1 72/21	action [2] 7/11 60/1
43/11 43/16 43/19 54/17 54/19 54/22	20 miles [1] 57/20	activism [1] 69/5
55/17 72/5 73/19 73/25 74/4 74/15 74/19	20 percent [3] 52/9 56/3 56/4	actually [9] 36/14 39/12 62/25 71/9 75/22
75/21 76/2 83/4 83/8 83/14 83/22 84/11	200 percent [1] 68/22	76/16 82/7 93/22 95/18
84/15 84/21 85/2 85/12 87/17 87/21 88/7	2023 [6] 1/15 13/18 64/12 70/16 100/12	acute [2] 8/13 8/20
94/24 95/3 95/8 96/20 97/10 98/20	100/16	acutely [1] 52/17
MR. DEARINGER: [11] 26/5 28/13	21 [3] 40/21 40/22 46/11	ADA [3] 24/21 25/8 59/9
28/25 29/5 32/16 32/19 42/1 42/8 43/1	22 [1] 48/24	add [7] 7/20 8/24 9/1 29/10 43/18 52/22
43/3 62/20	24 [2] 96/10 100/12	70/11
MR. DEROSSETT: [3] 66/23 66/25	25 [2] 50/2 69/21	added [5] 9/13 9/14 35/19 35/19 36/11
67/13	25 percent [1] 60/23	adding [1] 8/7
MR. OWEN: [2] 90/20 91/5	2:00 [1] 1/16	additional [5] 29/17 29/18 29/20 59/20
MS. ALLEN: [3] 77/2 88/21 88/23	2:00 Eastern [1] 98/8	68/23
MS. BICKERS: [7] 93/25 94/3 94/11 96/8	3	address [4] 28/10 50/22 52/4 84/11
96/10 96/14 96/16	30 [3] 61/21 69/21 72/21	adequate [1] 72/9
MS. KITCHEN: [4] 24/8 24/11 24/14	30 miles [1] 57/21	administering [1] 89/1
25/6	30 percent [2] 60/9 60/17	administrations [1] 10/7
MS. LEE: [2] 3/19 3/22	30th [1] 17/2	administrators [4] 10/8 76/15 79/9 79/19
MS. LOCKE: [7] 19/9 19/11 19/14 43/14	3:00 on [1] 42/3	admit [1] 13/16
43/17 43/20 70/9	4	adult [9] 32/4 32/23 40/24 59/20 61/12
MS. MEDINA: [5] 38/2 39/3 40/23 43/2	42s [1] 8/6	61/17 62/13 63/25 75/14
43/4	4341 [2] 32/16 32/18	adults [8] 39/12 39/15 41/3 42/25 43/8
MS. O'BRIEN: [8] 90/25 91/6 91/10	4342 [1] 32/1	43/21 62/7 75/7
91/13 91/17 91/20 92/3 92/17	46.25 [1] 61/18	advance [2] 6/1 6/6
MS. PARKER: [3] 66/24 67/15 67/22	49th [3] 10/2 10/13 10/20	Advisory [1] 100/10
MS. SHEETS: [13] 3/1 3/7 3/13 3/16 12/3	4th [2] 12/11 100/15	advocate [1] 30/12
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