

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

IN RE: OPTOMETRIC CARE TECHNICAL ADVISORY COMMITTEE  
MEETING

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November 7, 2019  
1:00 P.M.  
Cabinet for Health & Family Services  
Café Conference Room  
275 East Main Street  
Frankfort, Kentucky

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**APPEARANCES**

Matthew Burchett  
CHAIR

James Sawyer  
Steve Compton  
Gary Upchurch  
TAC MEMBER PRESENT

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**CAPITAL CITY COURT REPORTING**

TERRI H. PELOSI, COURT REPORTER  
900 CHESTNUT DRIVE  
FRANKFORT, KENTUCKY 40601  
**(502) 223-1118**

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APPEARANCES  
(Continued)

Judy Theriot  
Sharley Hughes  
David Gray  
MEDICAID SERVICES

Jean O'Brien  
Jan Thornton  
ANTHEM

Bethany Day  
HUMANA-CARESOURCE

Candace Gurley  
AETNA BETTER HEALTH

Stuart Owen  
WELLCARE

Nicole Allen  
Daniel Levy  
Mel Taylor  
Dale Miracle  
LeeAnn Ellis  
Meranda Sandlin  
AVESIS

Ronnie Smith  
John Davis  
EYEQUEST

Sarah Unger  
Dinah Bevington  
KENTUCKY OPTOMETRIC  
ASSOCIATION

Cindy Holman  
COMPTON & COMPTON EYE CARE

AGENDA

Call to Order/Introductions

Approval of August TAC Minutes

Avesis/eyeQuest update on foster care children discussion

How to improve Medicaid no-show patients

Lab codes versus surgical codes

MPPR and vision therapy codes

Future 2020 TAC Dates:

- \* February 6, 2020
- \* May 14, 2020
- \* August 6, 2020
- \* November 5, 2020

1 DR. BURCHETT: We'll call the  
2 meeting to order, and as usual, the first order of  
3 business is introductions.

4 (INTRODUCTIONS)

5 MS. HUGHES: And the  
6 Commissioner is probably not going to make it. She  
7 is not feeling well.

8 DR. BURCHETT: So, I guess  
9 before you all, you have the minutes from the last  
10 meeting and I think we've had time to review those  
11 previously. So, any additions, subtractions or  
12 changes? If not, I will entertain a motion to  
13 approve.

14 DR. COMPTON: Move to approve.

15 DR. UPCHURCH: Second.

16 DR. BURCHETT: All in favor.  
17 So, we've approved the minutes from the last meeting.

18 It looks like the first order  
19 of business is the foster care children discussion  
20 that we've had at the previous couple of meetings. I  
21 understand there's been some discussion amongst you  
22 all and we'd like to hear what you have come up with.

23 DR. LEVY: Great. So, what was  
24 wonderful is that we had open lines of communication  
25 with our colleagues and we looked at the population

1 and the children and the routine eye exam and the  
2 materials and the bottle-necking, the administrative  
3 hardship on getting approvals and getting these  
4 children in for services.

5 And with some dialogue back and  
6 forth, we were able to come up with a way that all of  
7 us would come together to offer foster care children  
8 and the benefits, and what we've come up with is  
9 we're going to remove the prior authorizations.  
10 There will be no post reviews.

11 So, the children will be able  
12 to come in. They have to be eligible at the time of  
13 service and eligibility when you check for that in  
14 the office. We want them to get the services they  
15 need. John, do you want to add anything?

16 DR. DAVIS: The goal really  
17 when we sat down together was to make sure that we  
18 did the same thing for everyone. You didn't have to  
19 do something different for EyeQuest or Anthem versus  
20 all the other programs through Avesis. So, that was  
21 the goal.

22 And, then, bottom line, it was  
23 just simple. It's like eliminate all the  
24 restrictions. The kids get unlimited eye exams if  
25 they need them. They get unlimited glasses, of

1 course, if they need them, and you guys were stuck  
2 with seeing these kids apparently sometimes at the  
3 last moment. The idea is we don't want you calling  
4 in saying I've got a kid waiting out there. Can we  
5 see them now? That's nonsense. So, the bottom line,  
6 those are all going to be gone, all those  
7 restrictions.

8 And, then, like was already  
9 stated, they have to be a member of the health plan.

10 DR. LEVY: Right. They have to  
11 be eligible at the time of service.

12 DR. DAVIS: But that's not  
13 going to be a big problem. I don't think that's  
14 probably a big deal. So far I haven't seen that to  
15 be an issue where there's a lot of retro terms of  
16 these kids, especially the foster kids that are  
17 coming through.

18 DR. UPCHURCH: Now, when you  
19 say eligible, let me get a little clarification. You  
20 mean eligible as be a member.

21 DR. DAVIS: Be on Medicaid.

22 DR. UPCHURCH: Because when you  
23 say eligible, they already had another eye exam.

24 DR. LEVY: No, no, no. And  
25 we're thinking - and we discussed this - this would

1 be a start of 1/1/20.

2 And I can even share. We have  
3 proposed language for this that we'll be adding to  
4 our plan sheet through the portal and I'll read it.  
5 Kentucky Medicaid children assigned to Kentucky MCO  
6 foster care group ID numbers are exempt from EPSDT  
7 prior authorization requirements for routine eye  
8 exams and replacement materials beyond the child's  
9 annual benefit limitation, and I think that's it, but  
10 we'll probably pop that up on the portal, and I'm  
11 sure our partners will do the same.

12 DR. DAVIS: Logistically, we're  
13 working on the systems right now. So, this  
14 effectively might happen sooner than the 1st because  
15 we're going to make it effective as soon as we can  
16 because we don't want to have you guys thinking about  
17 it, but between whenever, if somebody shows up in  
18 your office tomorrow and the claim gets denied,  
19 obviously you can have it reconsidered immediately.

20 We've already talked to our  
21 Customer Service Directors about how to answer the  
22 calls specifically to the foster kids. So, we're  
23 going to make sure that's part of the training that  
24 goes forward. That's why we're not going to make it  
25 official until the 1st so we can make sure everybody

1 is trained in that because it's a big deal. This is  
2 not the only state that this happens. Texas has the  
3 same problem. It's a huge issue with the foster  
4 kids.

5 So, I think it's going to work.  
6 Let's hope so because, again, we don't want you to  
7 jump through hoops and you don't have to do anything  
8 different between the different vendors which I think  
9 is a goal for you all as well because it's a hassle.

10 DR. UPCHURCH: I think the  
11 problem before was that it wasn't that you all didn't  
12 want to cover them because they were foster. It was  
13 that they weren't being identified as foster care  
14 children to start with. They may have gotten in the  
15 system but not notified through Medicaid. I don't  
16 know how that works.

17 DR. DAVIS: That's true.

18 MS. ALLEN: So, they will have  
19 to be assigned to a foster care group ID in order for  
20 them to be eligible for the referral or the prior  
21 authorization exemptions. If they're not in a foster  
22 care group ID yet, unfortunately, we will have to do  
23 the prior auth requirements.

24 So, if there's a way that we  
25 can work through that, that DMS can get the kids into

1 the system or into the correct group ID, then, the  
2 program does work but it is based on that group ID.

3 Basically, for that group ID,  
4 we're expanding the benefits for them, where all the  
5 other group ID's, they still have the routine and eye  
6 glass limitations that we have across the board for  
7 the others.

8 MS. HUGHES: Of course, the  
9 issue with us getting them in our system is how long  
10 it takes DCBS from the time they are made a ward of  
11 the state or whatever, then, DCBS processing them and  
12 changing their eligibility either from non-foster to  
13 foster or get them eligible for Medicaid if they  
14 weren't already eligible for Medicaid.

15 That's where we're running into  
16 some problems and I don't know if DCBS can increase  
17 that time any or not.

18 MR. SMITH: I have a question,  
19 just to kind of help me out. Say someone is new on  
20 foster care, do they come in with like some sort of  
21 confirmation, a binder? What is it that lets you  
22 know that they're a foster child?

23 DR. UPCHURCH: The problem that  
24 James and I have, and this affects us two probably  
25 the most, is we have children's - I don't know what

1 they call them - homes. Like, in my area, there's  
2 boys and they've got like a hundred and forty or  
3 fifty in them. And, so, they get new boys and girls  
4 in weekly. It's a detention type facility.

5 And, then, they are required by  
6 the State to get those kids' services done to show  
7 that they've done what they're supposed to do within  
8 a certain period of time.

9 So, we don't know until we get  
10 them in the office. They try to get us the  
11 information a day ahead of time and, then, we get the  
12 printout from Avesis or from EyeQuest that says they  
13 don't have any services available.

14 And, so, then is when we have  
15 been--I have been and I'm sure James is, too, pulling  
16 out that prior authorization. Now, at EyeQuest, I've  
17 gotten - and I don't know who it is right off that I  
18 have gotten that we call and just tell them and they  
19 say do it, that's not a problem, but with Avesis,  
20 we've been pulling out the prior authorization  
21 writing EPSDT or whatever those initials are all over  
22 it and, then, filling in the information, and  
23 recently that has been working pretty well for us.

24 DR. SAWYER: We haven't done  
25 that, I don't think. After we talked last, ours has

1 not been a problem that I've seen.

2 DR. LEVY: Yeah. We opened it  
3 up. We needed to make sure we can do it in the  
4 system to allow it to open up. That was the first  
5 piece, but it's officially going live 1/1 for us.

6 DR. SAWYER: I had a couple  
7 that came in with that group. They show on DMS'  
8 website on the portal as being eligible. Is that  
9 correct? We can check. I don't remember how my  
10 staff told me this worked but it was like it showed  
11 on yours but it didn't show on yours.

12 MS. HUGHES: Right. In our  
13 system, if they show in there as being a foster kid  
14 in our system, the Kentucky MMIS system is the system  
15 that you use for for eligibility.

16 If we change it today, then, it  
17 goes, from what I understand, it goes to the MCO  
18 tonight and, then, the MCO will process it and I'm  
19 assuming at that point sends it to Avesis or  
20 whomever.

21 DR. LEVY: Correct.

22 MS. HUGHES: So, it may take a  
23 couple of days for Avesis to get their system  
24 updated, but if it shows they are a foster kid on  
25 MMIS, KyHealth.net, then, you should be fine.

1 DR. BURCHETT: How long does it  
2 take for them to show on KyHealth.net?

3 MS. HUGHES: See, that's the  
4 problem. It takes DCBS changing their eligibility  
5 from the time they take them in as a foster child to  
6 either switch them from regular Medicaid over to a  
7 foster care group or if they've not been eligible for  
8 Medicaid and they come in to get them signed up, and  
9 that's where the issue, I think, is coming in.

10 DR. BURCHETT: Right, because I  
11 know in a couple of my offices, I have several foster  
12 families and they have been doing it so long that  
13 they know as soon as they get them, the next day  
14 they're going to the doctor and then they come to me  
15 after lunch. So, there's no turnaround. They know  
16 that that's what they have to do.

17 MS. HUGHES: If you take a kid  
18 in tonight and they say, okay, I'm taking these kids  
19 tomorrow to a doctor and we've not had time to get  
20 that into your system, it does create a problem.

21 If they're bringing something  
22 to you, especially for you all because most of yours  
23 are coming from that boys' home or boys' group or  
24 something, do they come with them and, like you said,  
25 do they have a----

1 DR. UPCHURCH: They have a  
2 counselor that comes with them. The coordinator or  
3 whatever calls our office the day before and tells us  
4 who we're going to have and we try to pull that  
5 information that night, but, still, even if the thing  
6 shows they're not eligible because we've been told  
7 they're going to be covered, we go ahead and see  
8 them, period.

9 And, then, we send in or call  
10 the EyeQuest person and we send in the other things  
11 from Avesis. And for a while, we sent those to  
12 Aletha, but LeeAnn is back now, so, we're good there.

13 I've not had as much problem  
14 since the last meeting because everybody got on board  
15 saying we'll do this. So, if there is a problem and  
16 it doesn't get approved, then, I just send it to  
17 Aletha and she has taken care of it.

18 MR. SMITH: So, like, for any  
19 member that is Medicaid eligible and it's in the  
20 system, our systems are going to be set up to handle  
21 those.

22 I think now we're trying to  
23 close that gap between when a member becomes foster  
24 care overnight and, then, they show up the next day  
25 and they're not in the system. I didn't know if

1 they had a form. We're talking about maybe you guys  
2 sending us something so we can know.

3 DR. BURCHETT: When the parents  
4 come in or foster parents come in, they have binders  
5 that they keep a record of their medical exams,  
6 dental exams or eye exams and all that. There's a  
7 form I fill out for foster kids.

8 DR. UPCHURCH: There's a travel  
9 form that shows that they've been there.

10 DR. BURCHETT: Yes, but there's  
11 actually a form that says date of service, what you  
12 found, when they need to come back.

13 DR. UPCHURCH: Yes, but it  
14 essentially just proves that they've been there,  
15 diagnosis, treatment.

16 DR. BURCHETT: But they take  
17 that and stick it back in that binder.

18 DR. LEVY: So, is there an  
19 opportunity for lag time here? That's what I'm  
20 hearing is that the children come in and they're not  
21 set up in the system quick enough. It doesn't go to  
22 the MCO quick enough and it certainly gets to us a  
23 little bit later.

24 Is there maybe a way we can  
25 hold them off for three days, and is three days the

1 number to get them up and in the system to show  
2 eligibility?

3 DR. THERIOT: If you're put in  
4 foster care, you're supposed to be seen by a  
5 physician within forty-eight hours and they're  
6 supposed to bring that binder, although a lot of  
7 times they don't but they will bring a piece of paper  
8 for you to fill out.

9 DR. UPCHURCH: The foster  
10 parents do bring papers.

11 DR. DAVIS: Does anyone in this  
12 room know the scope of this? Like, on any given day,  
13 how many foster kids are we talking about? Are there  
14 700 or 7,000 of them?

15 MR. GRAY: Within the system at  
16 any given time, it's right now roughly 9,500.

17 DR. DAVIS: Okay. So, it's  
18 substantial.

19 MR. GRAY: That's the total.

20 MS. HUGHES: That's the total.  
21 So, a lot of those are already in our system.

22 MR. GRAY: Total foster  
23 children roughly in the Commonwealth of Kentucky.

24 DR. DAVIS: So, it's hard to  
25 predict the percentage of them that become brand new

1 or switch to a new facility. Sometimes that happens,  
2 right, and, then, they still have to go through this  
3 again because you guys are obligated to see them  
4 again because the parents or whoever, the director of  
5 the home, has to.

6 DR. SAWYER: And that was the  
7 problem for us when they were being switched from one  
8 home to another and they used their eligibility a  
9 month ago. They got new glasses but they left them  
10 in the last place.

11 MS. HUGHES: So, even if a kid  
12 is in my foster home with me today but, then, I  
13 tomorrow say I can't continue to foster this child,  
14 so, they go to a new foster home, they have to be  
15 seen within forty-eight hours?

16 DR. THERIOT: Yes.

17 MS. HUGHES: I was thinking it  
18 was just coming in new to being a foster child.

19 DR. SAWYER: No. A lot of  
20 those problems that we had was that, that they were  
21 switching from one group home to this Otter Creek  
22 Academy that I have. So, if their eligibility was  
23 used according to Medicaid, according to everything  
24 that we knew, it was one year. So, I was left  
25 behind.

1 MS. HUGHES: But in those  
2 cases, they should already be in our system as a  
3 foster care child.

4 DR. SAWYER: That's why I think  
5 this is fixed now.

6 MS. ALLEN: So, this will fix  
7 that. It's the new ones. It's the children that are  
8 brand new.

9 MS. HUGHES: Right. So, the  
10 big question is how many on average in a week do we  
11 bring in that's new.

12 DR. DAVIS: Correct. Brand new  
13 ones, right.

14 DR. LEVY: And, then, to your  
15 point, Matt, you said that there's a form that you  
16 fill out. Would it be prudent to maybe accompany  
17 that form with the claim and, then, that's it. If  
18 that's the form, during claim submission, load that  
19 form in and we have it right there. There's the  
20 proof right there and it will automatically open it  
21 up.

22 DR. DAVIS: Is that reasonable  
23 to possibly do that, at least in some of them?

24 DR. UPCHURCH: I see no problem  
25 with that.

1 DR. LEVY: It's not like a  
2 prior auth. It's retrospective but at least during  
3 claim submission, you have that form.

4 MR. SMITH: It will just  
5 confirm for us that it is a foster kid and that  
6 allows us to open up that benefit for them.

7 DR. DAVIS: Well, and even  
8 without it, obviously we're going to take care of it  
9 but that sure gives you that support right away on  
10 the first go-around.

11 MS. HUGHES: I can't see that  
12 being an issue because obviously if they've been  
13 taken in by DCBS as a foster kid, they're going to  
14 have Medicaid eligibility. I'm not of the authority  
15 to be able to say, no, we can't do that or, yes, we  
16 can, but let me take it and ask Stephanie Bates and  
17 the Commissioner if we can't just do that.

18 If you're willing to do it and  
19 I can't see that there would be an issue because they  
20 automatically become eligible when they become a  
21 foster kid.

22 MS. ALLEN: So, if it's  
23 possible while you're doing your research, if you  
24 could please share with us a copy of that form and,  
25 then, that will give us the opportunity to research

1 it internally within our operating systems to confirm  
2 how we would set that additional process up.

3 So, we have one of two done.  
4 We still have the second one. We have the existing  
5 kids taken care of and now we need a solution for the  
6 new kids. Thank you.

7 DR. LEVY: This is a silly  
8 question but I have to ask it because it's on my  
9 mind. If you have a child that's in foster care and  
10 moves homes but you have seen that child within two  
11 or three weeks and you're the same practitioner,  
12 would you do another whole exam on that child?

13 DR. UPCHURCH: I never had that  
14 to happen.

15 DR. LEVY: Okay. So, it's not  
16 even a scenario that could happen.

17 DR. SAWYER: I've had repeats a  
18 year later that are still in that same Otter Creek  
19 and now they're back the next year. You know, for  
20 whatever reason, they usually don't stay a year but  
21 there have been a very small handful of those that  
22 have happened but it's their yearly exam time.

23 DR. UPCHURCH: Now, with the  
24 situation that we're in, those kids, they may--most  
25 of them have not been in foster care. They're being

1 committed to foster care immediately because either  
2 the families don't want them, the families can't take  
3 care of them or they've gotten into some kind of  
4 trouble that they've been ordered into that system.

5 And, so, there's where it comes  
6 to where they may have had an exam a month ago and  
7 used all their benefits and they weren't in foster  
8 care and now suddenly they are. It may not be for  
9 long because they may go AWOL. We have a few of  
10 those.

11 DR. LEVY: All right. So, I  
12 think this is a great solution and I appreciate  
13 working with you folks to come up with something  
14 like this. It's our first step to ease of  
15 administration and simplification.

16 MS. UNGER: So, that's for this  
17 room, but on the providers as a whole, how do we need  
18 to get the message across to everybody that this is  
19 happening? I know the KOA can send something.

20 DR. LEVY: We have that blurb.  
21 We'll share that blurb.

22 MS. ALLEN: We'll have it on  
23 the portal. We'll do a provider notification. Our  
24 PR reps know which offices are rendering these type  
25 of services to the foster care kids. So, they will

1 do some additional dedicated education with the  
2 providers. So, we'll educate as we normally do.

3 MR. GRAY: EyeQuest will do  
4 something similar?

5 MR. SMITH: That's correct.

6 DR. DAVIS: We've already  
7 written the verbiage for the portal. I don't know if  
8 it's up yet. I don't know who does that even but  
9 somebody does it.

10 MS. UNGER: And if you all  
11 don't mind to share your wording with us and, then,  
12 we can pass it along to our membership.

13 DR. DAVIS: Yes, because you  
14 guys do bulletins to your membership, right?

15 MS. UNGER: Yes, we do  
16 bulletins.

17 DR. DAVIS: That's really the  
18 best way because a lot of the OD's that are seeing  
19 these patients are KOA members.

20 DR. UPCHURCH: And if we get  
21 clearance on this I call it the travel sheet - it  
22 wasn't a travel sheet but it has the diagnosis and  
23 all that, if we get clearance on that, that's an easy  
24 thing to set right up. It's a very simple form.

25 DR. DAVIS: The only problem

1 with that is if you use the clearinghouse, I don't  
2 know how easy it is for you to upload that.

3 DR. UPCHURCH: We just go  
4 online and do your all's stuff on your website.

5 DR. DAVIS: Yes, you do the  
6 portal, right? That's beautiful. That's really  
7 good. And you can make it as simple as you need to  
8 as far as that is concerned. That really does  
9 support the claim. Now that's going to be walked  
10 through anyway.

11 DR. BURCHETT: Moving on, then,  
12 the next item is how to improve Medicaid no-show  
13 patients, a discussion for that, and I'm going to  
14 need some help because I can't remember what we  
15 discussed previously.

16 DR. UPCHURCH: Well, I was the  
17 one that brought it up to Sarah and just said is  
18 there any way we can encourage these people to show  
19 up. You have forty patients on the books and you  
20 have fifteen that no show and 80% of those are  
21 Medicaid.

22 MR. SMITH: I know on the  
23 dental side, there are some codes that have already  
24 been created. They're actually on the State's  
25 Medicaid fee schedule. They're for missed and broken

1 appointments. I don't think I've ever seen anything  
2 like that on the vision side.

3 So, on the dental side, we take  
4 those codes and we have added some sort of an  
5 incentive. So, if it is a missed visit for that  
6 provider, it's not a lot but it's like \$3 for that  
7 missed visit if you've used that code in a claim. Of  
8 course, this is on the dental side.

9 And, then, on top of that,  
10 we've added some outreach. So, when that claim is  
11 submitted and we see that code, we have a missed and  
12 broken appointments' brochure that goes out to that  
13 actual member and, then, we have two or three calls  
14 that are placed.

15 And, then, we hope that that  
16 would entice them to call you back and, then, we'll  
17 track it when you finally submit the other claim and  
18 we can actually see, oh, the service was done. We  
19 can see how long the lag took place and if they  
20 actually came back and completed their visit.

21 So, we do something similar.  
22 We have an outreach process. We have a process where  
23 we try to help that. We've seen some increases on  
24 the dental side. That's something, again, I think it  
25 starts with some codes and trying to do that maybe on

1 the vision side.

2 DR. UPCHURCH: That's  
3 interesting.

4 MS. ALLEN: And from the MCOs  
5 that we service for the Avesis team, we ask that you  
6 keep lines of communication open with us or with the  
7 PR reps. The PR reps will then share that  
8 information with me and I, in turn, reach out to the  
9 MCO and that they will do the outreach to the member  
10 to notify the member of the importance in keeping  
11 their appointments and maintaining the relationship.

12 DR. DAVIS: It's a problem  
13 that's across every specialty and it's a problem with  
14 the population. We know that. Thirty-three years I  
15 practiced and I had the same thing. It was a  
16 nightmare.

17 DR. UPCHURCH: It is.

18 DR. DAVIS: And you just  
19 counted on it and it's a shame but, ultimately, you  
20 guys, does the State let you put a policy in place  
21 that if they miss a certain number of times, they're  
22 not welcomed to your practice anymore? How does that  
23 work?

24 DR. SAWYER: I can't afford to  
25 do it. I have to have them.

1 MR. OWEN: I know actually it's  
2 been explored before with Medicaid Programs and  
3 basically the federal government won't allow that.  
4 There have been proposals to lose eligibility for a  
5 period of time and it's always not been allowed.

6 DR. UPCHURCH: I had one  
7 Medicaid lady that no-showed seventeen times. The  
8 last time she showed up because she developed  
9 metastatic cancer and the cancer doctor told her that  
10 you have to go get an eye exam, period, and she  
11 showed up finally. And I had already - maybe I'm not  
12 legal on that - I had already said don't even put her  
13 on the books. If she shows up, I will see her but  
14 don't even put her on the books. Don't take up  
15 space. Maybe I'm not allowed to do that.

16 DR. DAVIS: I know I did it,  
17 exactly that. It wasn't in Kentucky.

18 MS. HUGHES: In my opinion, you  
19 at least said you would see her if she shows up.

20 DR. UPCHURCH: If she showed up.

21 DR. LEVY: That's all that  
22 matters. We were talking about this earlier this  
23 week and I wrote some notes down from our  
24 conversation. In some instances, we don't have  
25 the ability to communicate directly to the members,

1 if I'm not mistaken.

2 So, we always go back to our  
3 MCO health plan partners and ask them, what are you  
4 guys doing overall when these people enroll in the  
5 program as a communication, constant education,  
6 either texting, a re-call case management.

7 And if there's an opportunity  
8 for us as your partners on the eye care side to help  
9 you with that, we would be certainly open to that.

10 I do like the idea of the  
11 coding because that's a great way to track it because  
12 that would be the only way we would be able to track  
13 it. And, then, the only way we would be able to  
14 track it is if you practitioners used that code,  
15 almost like a CPT-2 code, to say, hey, these folks  
16 didn't show up and, then, we would be able to go back  
17 and look and start to do trained analytics on that to  
18 see population and who is not.

19 And, then, we go back to our  
20 MCO partners and say this is what's going on because  
21 I'm sure you all have a re-call within your offices  
22 to call your folks within twenty-four or forty-eight  
23 hours to remind them that you have an eye exam or an  
24 appointment coming up.

25 MR. OWEN: And like WellCare

1 and I'm sure other MCOs, people that are in case  
2 management, they do give very aggressive outreach but  
3 it's just those that are in case management. It's  
4 not everybody. We've got an app that does send  
5 alerts to people who do have a smartphone and can  
6 download the app.

7 DR. UPCHURCH: They all have  
8 smartphones. You all buy them smartphones, right?

9 DR. DAVIS: Are there any tools  
10 like transportation companies use because they have a  
11 huge problem with this, too?

12 MR. OWEN: Right, because they  
13 actually go. They go to pick them up and they're  
14 like I'm not going. They spend gas and time.

15 DR. DAVIS: Dr. Upchurch, I  
16 wish there was a better way.

17 DR. UPCHURCH: I know. I've  
18 had them call this morning saying, hey, I've got an  
19 eye emergency. We put them down this afternoon and  
20 they don't show. Then they call me at 11:00 at  
21 night.

22 MS. HUGHES: And want you to  
23 come back to the office.

24 DR. UPCHURCH: And I do.

25 MS. ALLEN: Is it possible to

1 request that the same codes that we have for dental,  
2 the two codes that we have for dental for the no  
3 shows are considered to be added for the provision  
4 and, then, that way we can start the process of  
5 tracking?

6 DR. BURCHETT: What are the  
7 codes?

8 MS. ALLEN: It's D99--I have  
9 them.

10 DR. LEVY: And it's nothing  
11 similar. They're just general CPT?

12 MS. ALLEN: We would need DMS  
13 to designate those as missed appointment codes. That  
14 way, the encounters, we don't have any complications  
15 with the encounters.

16 MS. UNGER: So, it's the last  
17 two codes on the dental?

18 MS. ALLEN: Yes.

19 MS. HUGHES: And I'll check  
20 with the Commissioner and so forth.

21 MS. UNGER: Send it to Charles  
22 maybe.

23 MS. HUGHES: I'll have to check  
24 with Stephanie or the Commissioner and see if we can  
25 do it. If we're doing it for dental, I don't see why

1 we couldn't do it for vision.

2 MS. UNGER: Are those codes on  
3 like just the physician's fee schedule also or is it  
4 just on dental?

5 MR. SMITH: It's just on the  
6 dental fee schedule.

7 DR. LEVY: That's what I'm  
8 saying. Is there something on major medical, they're  
9 a CPT-1 or a CPT-2 code that we could back into to  
10 use those codes?

11 MS. ALLEN: We've had them on  
12 dental for about three years.

13 MS. HUGHES: As you said, it's  
14 across all providers and it is bad. They make  
15 arrangements for transportation to come and pick them  
16 up, and, then, when they come to pick them up, they  
17 say, well, I'm not going. So, we've paid out for the  
18 transportation to come pick them up and everything.

19 DR. COMPTON: That's  
20 interesting. Transportation people get paid for a no  
21 show but we don't.

22 MS. HUGHES: Well, now, I say  
23 that. I'm assuming but I don't know.

24 DR. COMPTON: Well, we're  
25 throwing that out there.

1 MS. HUGHES: I may have spoken  
2 wrong there, Dr. Compton.

3 DR. BURCHETT: There is no CPT  
4 code for missed appointment.

5 DR. LEVY: I didn't think.  
6 What about a HCPC? Probably not, right?

7 DR. DAVIS: I've never seen  
8 one.

9 DR. UPCHURCH: I think if there  
10 was, we would have seen it by now in thirty-some-odd  
11 years.

12 DR. DAVIS: And I just went  
13 through the CPT-2's, all thousand of them, and I  
14 don't remember seeing anything like that.

15 MR. SMITH: It's on the dental  
16 fee schedule. It's D9986. That's described as a  
17 missed appointment and, then, D9987 is described as a  
18 cancelled appointment.

19 DR. UPCHURCH: Maybe if there  
20 was some kind of an incentive for the insurance. We  
21 just had a HEDIS thing this week where they called  
22 and made the appointment. They called the next day  
23 and said did he come and now can you send us a copy  
24 of the records.

25 DR. LEVY: Because the greater

1 the utilization, the greater the outcomes, right?  
2 The whole idea is to push these folks in to get the  
3 services, be it dental or eye care.

4 DR. UPCHURCH: Well, you don't  
5 hardly ever see anybody anymore with rampant  
6 retinopathy like we used to, very few and far  
7 between. They used to walk in twenty years ago and  
8 they were just in bad shape. So, preventative care  
9 works.

10 DR. BURCHETT: Okay. So,  
11 moving forward, lab codes versus surgical codes, and  
12 I think this was something Steve brought to our  
13 attention.

14 DR. COMPTON: We're getting  
15 office visits denied when we bill the office visit  
16 along with a lab code for tear film analysis and  
17 sometimes you pay them. I've got some EOB's here and  
18 sometimes you deny them.

19 So, we reached out to our  
20 Provider Relations and let me just read it to you.  
21 We have had denials for office visits 99213 dealing  
22 with dry eye testing. The code is 83861, 83516.  
23 They were denied because they required a modifier,  
24 medical records and/or was billed with a surgical  
25 procedure. These previously have not been denied and

1 listed below is one that recently has been paid. Can  
2 you look into this for us? Patient information is  
3 listed below.

4 Here's the response. Good  
5 afternoon, Cindy. Please refer to the coding for  
6 surgical procedures when exams are billed the same  
7 day. The claims were denied properly. Let me know  
8 if there's anything additionally----

9 MS. ALLEN: Excuse me for a  
10 second, Dr. Compton, because we have good news.

11 DR. COMPTON: Pardon me?

12 MS. ALLEN: Because we have  
13 good news.

14 DR. LEVY: We fixed the glitch.

15 DR. COMPTON: Okay. So, now we  
16 can get paid?

17 MS. ALLEN: Yes.

18 DR. LEVY: I want to let you go  
19 on but you're 100% right. It was coming in with the  
20 surgical procedure showing up as a surgical procedure  
21 even though it was a test and we were denying it that  
22 way, and I was told it was fixed Monday.

23 DR. COMPTON: These were at the  
24 end of September when we did the emails for June  
25 claims.

1 MS. HUGHES: So, can they go  
2 back to June?

3 DR. LEVY: We'll take care of  
4 it.

5 MS. HUGHES: There you go, Dr.  
6 Compton.

7 DR. LEVY: And, again, Sarah,  
8 thank you for bringing that to our attention before  
9 the TAC so we had the opportunity to do the research  
10 to say, well, what's going on the system.

11 DR. COMPTON: We had reached  
12 out. And my response to her is, okay, we're getting  
13 paid ten bucks. Let's don't spend any more time on  
14 this. Well, ten bucks. We were getting paid for the  
15 lab codes but not the office visit.

16 DR. LEVY: It wasn't on you.  
17 It was on us and we fixed it. And we, again,  
18 appreciate the examples because when you send the  
19 example, we can go into the system and see what's  
20 going on and we caught it like that real quick.

21 DR. COMPTON: So, for anything  
22 like that, as long as we've reached out to the  
23 Provider Relations and we know what's wrong, where do  
24 we reach next? Do we go through all that appeals  
25 process and all that?

1 MS. ALLEN: There is an  
2 appeals process, but please continue to reach out.  
3 Meranda actually had the examples that she was able  
4 to share with us, so, we were able to take that and  
5 had the claims configuration team review it with Dr.  
6 Levy. Dr. Levy stated how it should be processed and  
7 we were able to update the system.

8 DR. LEVY: So, that process was  
9 great.

10 DR. COMPTON: Thank you.  
11 That's fixed.

12 DR. BURCHETT: So, are you  
13 good, Steve?

14 DR. COMPTON: I am good. If  
15 it's fixed, I'm good. We're not here to do  
16 individual stuff but that had to be across the board.

17 MS. ALLEN: It was.

18 DR. BURCHETT: And if I'm not  
19 mistaken, you brought the next one to our attention  
20 as well.

21 DR. COMPTON: Yes, which  
22 someone else brought to my attention. I'm going to  
23 need your guys' help on this.

24 We got - I didn't get it -  
25 somebody sent it to me - correspondence on vision

1 therapy codes, something is not going to be paid.  
2 And I'm not familiar enough with vision therapy codes  
3 but I said I'll bring it.

4 DR. LEVY: Again, we'll take  
5 that one as well. So, was it two years ago that we  
6 sent out a communication about MPPR, multiple  
7 procedure payment reduction, a CMS guideline. You  
8 get paid 100% of the first and, then, 50% on second  
9 and third.

10 So, we follow that in all of  
11 our lines of business in all states that we provide  
12 eye care services. So, we had - and we can share -  
13 there's a list of codes that are used for vision  
14 therapy and some are impacted by the MPPR and some  
15 are not.

16 And those that are, based on  
17 whatever the first code comes in, you get paid 100%.  
18 The second, third, fourth, fifth, it's 50% all the  
19 way throughout, if I'm not mistaken.

20 MS. ALLEN: That's correct.

21 DR. LEVY: And it's working  
22 well on our side. And, so, I guess what came up is  
23 that some of the vision therapists - I think there's  
24 twelve practices through the whole state.

25 MS. ALLEN: Yes.

1 DR. LEVY: So, we had an  
2 education with them and, then, we decided to put a  
3 general education out to everyone so everyone  
4 understood.

5 So, if there are still  
6 questions and you're getting questions, we need to  
7 get back and have another discussion with those  
8 practices.

9 DR. COMPTON: I don't know  
10 enough to question it. In my mind, it's like, okay,  
11 are they dropping a code that they should be paying.

12 DR. LEVY: Well, one code was  
13 reviewed. The 96111 is no longer, right? It's  
14 96112, 113. Those are the two.

15 MS. ALLEN: Yes.

16 DR. LEVY: And, then, it goes  
17 right into the 97110, 112 and 97530 which are more of  
18 those PT, OT type codes which takes vision therapy  
19 well beyond which is actually kind of cool.

20 But I did check the system this  
21 week and I was given examples again from the team and  
22 we are doing it and paying correctly.

23 DR. COMPTON: So, the one  
24 that's been removed is replaced by----

25 DR. LEVY: Right.

1 DR. BURCHETT: And we've had  
2 that updated on the fee schedule, the code that was  
3 removed.

4 MS. UNGER: Yes. Earlier this  
5 year, Medicaid removed the old code and added the new  
6 code.

7 DR. COMPTON: And this is a  
8 fairly new practitioner. So, I've learned enough  
9 right here I can go back and explain it. It'S also  
10 my daughter-in-law.

11 DR. UPCHURCH: So, the question  
12 is, is this an approved thing by Medicaid to do this  
13 MPPR?

14 DR. LEVY: Yes, it is.

15 MS. ALLEN: We're in line.

16 DR. LEVY: Now, I'm not 1,000%  
17 sure that the State has adopted MPPR but we certainly  
18 have this. We're following CMS guidelines and I'm  
19 pretty sure they do but don't quote me on that.

20 DR. DAVIS: If you look at the  
21 CMS, the full documentation of every CPT code under  
22 CMS, they all have an indicator for MPPR,  
23 bilaterality, second surgeon. There's a bunch of  
24 them.

25 MR. GRAY: It goes way beyond

1 just vision.

2 DR. DAVIS: Like, if it has an  
3 indicator of one or two, that means it's subject to  
4 the MPPR. If it's zero or none, it doesn't. It  
5 specifically spells it out.

6 DR. LEVY: Have your daughter-  
7 in-law call us and we'll go over the modifiers. These  
8 new 9700 codes are time codes. I have it on a  
9 visual.

10 DR. COMPTON: She's much  
11 smarter than I am.

12 MS. ALLEN: Please let us know,  
13 Dr. Compton, if you need more explanation.

14 DR. COMPTON: I will. I think  
15 I've got the explanation I need.

16 DR. LEVY: And does not our fee  
17 schedule have what is MPPR and what is not?

18 MS. ALLEN: There's a column.

19 DR. LEVY: So, it's stated  
20 right on our fee schedule which is connected to our  
21 portal. You'll be able to see that and you'll see  
22 that asterisks and that will tell you that that's a  
23 code that's affected by MPPR.

24 DR. UPCHURCH: When you say you  
25 go by CMS guidelines, is that Medicare guidelines?

1 Is that the same guidelines that Medicare goes by on  
2 everything?

3 DR. LEVY: Yes.

4 DR. UPCHURCH: So, if that's  
5 the case, why do we not go by the same Medicare  
6 guidelines on what's approved for visual fields and  
7 for photos and for those kind of things? You all  
8 have your own guidelines on the diagnoses that you  
9 will cover there. So, why do we steer away from CMS  
10 there if we're going to follow CMS here?

11 DR. LEVY: Good question. One  
12 is different because it's coding and billing set up  
13 by CMS. The other is our ability to look at  
14 analytics and set up our guidelines and protocols  
15 based on services coming in.

16 So, in some instances, we have  
17 removed prior auths and changed things in post review  
18 and opened things up for emergent care based on the  
19 approval and no denials and having the right  
20 documentation.

21 So, in 2020, to your point, as  
22 we start doing further and further analytics, we may  
23 shift things from prior auth to post review or take  
24 something completely off prior auth and post review  
25 for certain practices that have shown that they

1 understand the guidelines and protocols that we have  
2 set.

3 Our guidelines and protocols  
4 are based on best practices, also by the CMS  
5 guidelines, by American Optometric Association, the  
6 Academy of Optometry and Ophthalmology.

7 So, they're not necessarily the  
8 same things. One is for everything and the other is  
9 just for vision direct on how we come up with our  
10 protocols and guidelines.

11 MS. HUGHES: And can I ask a  
12 stupid question?

13 DR. LEVY: No such thing.

14 MS. HUGHES: MPPR, multiple  
15 procedure something reimbursement?

16 DR. LEVY: Payment reduction.

17 MS. HUGHES: Payment reduction.  
18 They probably know it but I didn't.

19 DR. DAVIS: Mostly it applied  
20 to multiple surgical procedures like cataract surgery  
21 with a valve replacement or a surgery where the  
22 surgeon does three different muscles and things like  
23 that.

24 DR. UPCHURCH: Of course,  
25 you're talking about high-end costs there. These are

1 small amounts to start with.

2 DR. LEVY: But the prior auths  
3 are at the discretion of the health plan and the  
4 dental partner or the eye care partner.

5 So, when I go in to new states  
6 and I look at the fee schedule from a new MCO, I can  
7 see where their prior auths are for their services  
8 that they're rendering - and some of them are high  
9 care in dental - where their post reviews are.  
10 Sometimes in states, they are a little bit more  
11 stringent. Sometimes they're a little bit less.

12 We use our overall  
13 understanding of eye care services because that's  
14 what we do all day long and we put things based on  
15 where they are in that new fee schedule and, then, we  
16 use history and time to open and change things as we  
17 see fit.

18 DR. UPCHURCH: Well, I don't  
19 want to get out of line here but it sounds to me like  
20 that we're going by CMS when it's convenient. We're  
21 going by what we want to do when it's not. I mean,  
22 that's the appearance. If we're going to follow CMS,  
23 let's follow CMS.

24 DR. LEVY: We're following CMS  
25 for certain things. We didn't say we follow CMS for

1 everything.

2 DR. UPCHURCH: When it's  
3 convenient.

4 DR. BURCHETT: That's what you  
5 just said.

6 DR. UPCHURCH: That's what I  
7 just said. When it's convenient, you follow CMS.  
8 When it's not----

9 DR. LEVY: Well, I guess that's  
10 a way of looking at it, but MPPR is not just for eye  
11 care, as we stated. It's for all procedures for all  
12 specialties.

13 DR. UPCHURCH: I understand  
14 what you're saying about the MPPR but I'm also  
15 talking about visual fields. The diagnosis list that  
16 Medicare allows is a lot different than the diagnosis  
17 group that you allow. Okay?

18 For example, diplopia, Medicare  
19 says it's appropriate to do a visual field. You all  
20 will deny it. So, if we're going to follow CMS,  
21 let's follow CMS. The same way on diagnosis codes.  
22 We've got four refractive diagnosis codes that CMS  
23 identifies. Let's stay with those four diagnosis  
24 codes on refraction.

25 DR. LEVY: I appreciate that

1 but I've got to tell you CMS is not a specialty in  
2 eye care like we are and we look at trends and  
3 analytics all day. And I think what we have put in  
4 place is pretty darn fair when you come from our  
5 profession. I'm not sure I know of any CMS medical  
6 director that is an eye care specialist.

7 So, again, it's at the  
8 discretion of the health plan and at the discretion  
9 of the partner of the health plan. We try to be  
10 pretty open with that and have opened things up.  
11 And, so, there's opportunity to do so.

12 I think that our diagnosis to  
13 CPT is pretty close. Again, on my team, I have  
14 optometrists and ophthalmologists that are doing this  
15 all day long and we are a specialty of our MCO  
16 partners that look at this. We're just trying to  
17 minimize waste and ensure that services are based on  
18 medical need.

19 DR. UPCHURCH: I'm not going to  
20 butt my head against the wall. There's no use in it  
21 but there are certain diagnoses that we need to have  
22 opened up to be able to do things.

23 DR. LEVY: And I would be open  
24 to have that discussion, sure. There's plenty of  
25 flexibility here.

1 MS. ALLEN: So, that's  
2 something we can take offline and it's something that  
3 we can definitely follow up on. Is that okay?  
4 DR. UPCHURCH: Sure.  
5 DR. LEVY: You know what would  
6 be great? Why don't we start even taking it a little  
7 further. Make some suggestions on some of those and  
8 I will take a look at it with my team and we'll get  
9 back to you. How is that for flexibility?  
10 DR. UPCHURCH: Sure. I'll do  
11 that.  
12 MS. ALLEN: So, LeeAnn will be  
13 in touch with you.  
14 DR. BURCHETT: Looking at the  
15 agenda, we've got TAC dates for 2020. I think we've  
16 all had a chance to look at those dates. Anybody  
17 have any trouble with any of them? I think that's  
18 what we put forth previously.  
19 So, if we're all good with  
20 those dates, then, we will keep up with those for  
21 next year's quarterly meetings.  
22 MS. HUGHES: And I will get  
23 with the Commissioner and Deputy Commissioner on the  
24 forms from the foster kids and the missed appointment  
25 codes and about the multiple procedure payment, if

1 DMS is following that, multiple procedure payment  
2 reduction.

3 DR. BURCHETT: Will we expect  
4 an email followup before next TAC meeting on that?

5 MS. HUGHES: Yes. I'll try to  
6 get you an email out to let you know.

7 DR. UPCHURCH: Can I ask one  
8 more question? I just wanted to ask Dr. Levy. On  
9 that reduction, the PT guys are going to be calling  
10 me - I know that - if they've not already been in  
11 contact with you and straightened it out.

12 So, the first one is paid at  
13 100%.

14 DR. LEVY: Correct.

15 DR. UPCHURCH: The second one  
16 is paid at 50.

17 DR. LEVY: Correct.

18 DR. UPCHURCH: The third one,  
19 if they use a third one, is paid at 25?

20 DR. LEVY: Fifty percent.  
21 Fifty percent all the way after that.

22 DR. UPCHURCH: Okay. So, the  
23 first one is 100. Everything else is 50.

24 DR. LEVY: That's correct.

25 DR. DAVIS: There aren't many

1 of the therapy codes that are subject to the MPPR.  
2 DR. LEVY: That's correct.  
3 DR. DAVIS: There's only a  
4 couple of them out of the six or so that are----  
5 DR. UPCHURCH: I think Sarah  
6 sent me that.  
7 MR. LEVY: It's three.  
8 MS. UNGER: They're saying they  
9 sent out, so, you should have received those.  
10 DR. UPCHURCH: I did not  
11 receive it.  
12 MS. ALLEN: This is what it  
13 looks like, if that looks familiar, but we can get  
14 you another one.  
15 DR. LEVY: It's only three  
16 codes and those are those PT, OT which is a newer  
17 type of codes for the newer generation of doctors  
18 that are taking vision therapy a little bit----  
19 DR. BURCHETT: Do you mind  
20 telling me what those codes are, then?  
21 DR. LEVY: It's 97110, 97112  
22 and 97530.  
23 MS. ALLEN: What we did realize  
24 what the providers originally were doing is that they  
25 were billing the first for the right eye and the

1 second for the left eye but it applies to both eyes  
2 and it's their time. So, the first fifteen minutes  
3 which includes the right eye and the left eye is at  
4 100%. The second fifteen minutes, right and left  
5 eye, is what's reduced that 50%.

6 So, we did have to do some  
7 education with the providers to help them understand  
8 that it was timed for vision therapy and, then, the  
9 initial--include whatever you did on both eyes. If  
10 you treated one eye or two eyes, that was still  
11 included in the first fifteen.

12 DR. UPCHURCH: And all three of  
13 these are time codes.

14 MS. ALLEN: Yes. They're all  
15 time codes.

16 DR. UPCHURCH: They require  
17 fifteen minutes for the first--well, actually, it's  
18 one to eight minutes. It's got to be over eight  
19 minutes. It can be less than fifteen. But, then, if  
20 you go to the second level, it's got to be between -  
21 I forgot the exact number - something, fifteen and  
22 twenty-three. Anything above twenty-three, then, and  
23 up to thirty is still just two codes. Now, if we're  
24 following CMS. That's what Medicare does.

25 DR. LEVY: Right. One of my

1 guys on my team did vision therapy for a career. So,  
2 I'll get back to you on how that goes.

3 DR. UPCHURCH: But typically I  
4 think what most of them are doing is just using--they  
5 should be just using one unit for the visit. They  
6 should not ever be billed per eye. These are not  
7 per-eye codes.

8 DR. LEVY: Right. It's  
9 bilateral.

10 DR. DAVIS: I don't think any  
11 of the guys that are doing it here are doing that  
12 that I've seen.

13 DR. UPCHURCH: Well, if they  
14 are, we need to educate them.

15 DR. LEVY: I always thought the  
16 biggest code was either the 92060 or the 92065. In  
17 my day, that's what I was using.

18 DR. UPCHURCH: The 92065 was  
19 all that was available, but now since then, the  
20 medical insurances have opened up.

21 DR. LEVY: Added the 96 and  
22 97's. Okay.

23 DR. UPCHURCH: And realized  
24 that the things that we were doing actually was  
25 falling in those categories. Okay. I'm good.

1 DR. BURCHETT: Just on maybe  
2 some new business and/or informational type of stuff  
3 and this is for really the Department.

4 We had heard that the new MCO  
5 contracts, we would be alerted to who received those  
6 sometime in November, if I'm not mistaken. I'm not  
7 asking who got them. I'm just asking what does the  
8 time frame look like?

9 MS. HUGHES: I'm not real sure.  
10 We're hoping it will be soon.

11 DR. LEVY: Soon in November?

12 MS. HUGHES: We hope. We don't  
13 really know for sure and we're really not allowed to  
14 say anything either.

15 DR. BURCHETT: Well, and I know  
16 that.

17 MS. HUGHES: But I honestly  
18 don't know.

19 DR. BURCHETT: I seem to  
20 remember somebody at some point in time said that----

21 MS. UNGER: I thought they said  
22 the MAC.

23 DR. BURCHETT: Yes, the MAC.

24 MR. OWEN: At the late  
25 September MAC, the Commissioner said it's anticipated

1 in November.

2 DR. BURCHETT: Right. Okay.  
3 That's where I've seen it, then. Anyway, I just  
4 didn't know if there was any update on a time line.

5 DR. COMPTON: It was worded  
6 very carefully.

7 DR. BURCHETT: And, then, the  
8 other thing I have an update on is, not to go into  
9 great detail, I know that at the last TAC meeting, we  
10 had some discussion on the retinal screening photos  
11 that had occurred.

12 And myself and Sarah and Dinah  
13 were on a conference call with the medical director  
14 from one of the companies that was in charge of doing  
15 that and we had gotten some information and she is  
16 going to send to me a synopsis of the program and the  
17 discussion that we had.

18 So, I will pass that along to  
19 the rest of the TAC members as soon as she forwards  
20 that to me.

21 MS. ALLEN: And did you receive  
22 the summary that we provided to you?

23 DR. BURCHETT: Yes. We  
24 received that way before I had that meeting and I  
25 just wanted to update you guys since we had talked

1 about that.

2 DR. LEVY: I have a question  
3 for you folks. I know you were thinking about  
4 rethinking the telemedicine/telehealth on synchronous  
5 and asynchronous. Any update? You were going to  
6 push against that, I thought, or try to get that,  
7 right?

8 MR. OWEN: Well, I will say  
9 this. DMS filed an amended reg and it basically has  
10 some caveats. It's subject to the availability of  
11 funding. They did add, I think, asynchronous for  
12 about maybe ten different categories.

13 DR. LEVY: Radiology being one.

14 MR. OWEN: Yes, that was  
15 initially and it was restricted to that and then it  
16 says others may be considered subject to funding and  
17 will be posted on the website.

18 DR. LEVY: But nothing as much  
19 as retinal imaging, retinal photo, retinal screening.

20 MS. BEVINGTON: They actually  
21 added optometric services. So, in the amended reg,  
22 it's covered with telemedicine as well.

23 DR. LEVY: That's great.

24 MS. ALLEN: So, we just have to  
25 wait for the funding.

1 MR. OWEN: Well, if it's in  
2 there, it's covered. If it's in the reg and the  
3 list, then, it's covered. It was additional ones  
4 would be subject to funding.

5 DR. LEVY: You'll have a chance  
6 with the ophthalmologists to be able to participate in  
7 this which is what you want. You can use in-house  
8 OD's. Just like they're using in-state OMD's, now  
9 you will have that same ability which is important.  
10 Great.

11 MR. GRAY: As I told one of the  
12 TACs, we're doing really telehealth, it's kind of  
13 like in church, you have a faith budget. Telehealth,  
14 we have a faith budget, meaning we don't have a  
15 budget but we're depending upon faith to make this  
16 work.

17 DR. BURCHETT: Sarah just  
18 reminded me. Some of my office staff has come to me  
19 and asked which of the MCOs will be covering adult  
20 glasses moving forward because they had heard that  
21 some weren't and people were trying to call and  
22 schedule to get in before the end of the year because  
23 they had heard that their MCO was going to stop and  
24 somebody else was going to start having adult  
25 glasses.



1 like I don't know.

2 DR. DAVIS: We would know by  
3 now if they were changing benefits for January 1.

4 DR. BURCHETT: That's what I  
5 thought. There would be a notice sent out on that.

6 DR. SAWYER: I have a question  
7 about that, by the way, too. How do you determine  
8 when a person is--I've had a couple here in the last  
9 little bit. They've been Medicaid children. They  
10 turned 21. They've gotten their glasses last year at  
11 age 20 or whatever. Now they're beyond child age and  
12 now they're with WellCare. When are they eligible  
13 for their adult glasses?

14 MS. ALLEN: So, for the adults  
15 - and I'm going to ask for LeeAnn and Meranda to keep  
16 me honest - for the adults for both Aetna and for  
17 WellCare, it is based on the service date. So, their  
18 eligibility is once every two years based upon the  
19 service date.

20 The children, on the other  
21 hand, is based on a calendar year. So, that's the  
22 difference.

23 DR. SAWYER: Some of them have  
24 looked like it's going to be three years between.  
25 The way it looked like on the portal, it was looking

1 like their eligibility for their adult glasses was  
2 two years away. They had had a pair early when they  
3 were 20. So, it's been almost three years in  
4 between.

5 DR. BURCHETT: So, you're  
6 saying when they moved from the children age to the  
7 adult, that benefit doesn't reset.

8 MS. ALLEN: No, it does not  
9 reset but they will go from--so, let's say someone is  
10 20. Their birthday is in December. They receive  
11 glasses in November. So, they're 20. They receive  
12 glasses. They would be eligible for new glasses as  
13 an adult--I mixed myself up.

14 So, they would be eligible for  
15 new glasses at the age of 21 and, then, at the age of  
16 23 because it's two years.

17 So, the three years, it could  
18 possibly be but if there is an extreme medical  
19 condition or it changes mor than ten----

20 DR. LEVY: No. If someone  
21 comes in and there's a big shift or something, put a  
22 prior auth in place. Remember, it's a value-based  
23 program, right? So, it's a value-added program.  
24 It's not set up on any specific guidelines by the  
25 State or DMS.

1                   So, again, we offer quite a bit  
2 of flexibility there. If someone comes in and you in  
3 your professional observation decide that they need  
4 something quick, put a prior auth, put your notes in  
5 there, put it into the claim and, again, another peer  
6 will review it and we'll make a determination based  
7 on that.

8                   MS. ALLEN: But it is difficult  
9 when it goes from year to date of service. Adult is  
10 date of service. Children is based on a calendar  
11 year.

12                  DR. UPCHURCH: And there's  
13 nothing in place coming or anything from Passport or  
14 Humana that they're going to do any adult?

15                  MS. ALLEN: At this point, it  
16 is the existing benefits. And once we get the new  
17 RFP, then, they'll know what they can work with or  
18 what they will be offering.

19                  DR. DAVIS: Could I ask a  
20 related question from the doctors that are on the  
21 committee and practicing?

22                               Do you think that the members  
23 who have diabetes are now incentivized to come in for  
24 that annual because they now have an eye glass  
25 benefit that some of the plans are giving them? Do

1 you think it has helped to make it easy access?

2 DR. BURCHETT: I think it has  
3 helped across the board, not just diabetics. I've  
4 seen numerous people that I haven't seen in seven or  
5 eight years and they say, yeah, I've got benefits to  
6 get glasses now, so, I can come.

7 DR. LEVY: I have to agree with  
8 you. On our claims, I can tell you that's the case.  
9 Utilization has spiked up quite a bit, people that we  
10 haven't seen.

11 When you offer the benefit,  
12 some people will come in because it's I medically  
13 need to get something because something is wrong with  
14 my eyes. If you put that material component in, even  
15 on a commercial program, and you up a nice material,  
16 they come in because they had the ability to get a  
17 pair of glasses.

18 DR. DAVIS: I don't want to  
19 speak for all the health plans but this gentleman  
20 would probably know, too, that that went into the  
21 thinking of adding these supplemental benefits is can  
22 we incentivize people to get them to come in.

23 DR. SAWYER: I still have a  
24 lot of patients, though, that will only come every  
25 two years. They won't come in that off year.

1 DR. UPCHURCH: The EyeQuest  
2 will because EyeQuest is covering it every year. So,  
3 they're more likely to come every year, whereas your  
4 other MCOs - and I say EyeQuest but it's Anthem - the  
5 other four MCOs, since they only do it every two  
6 years, typically you will see those adults every two  
7 years.

8 DR. LEVY: Unless they fall  
9 within a medical type thing and, then, they come in  
10 for medical.

11 DR. UPCHURCH: Unless they're  
12 severe diabetics and you can preach to them good.

13 DR. LEVY: There's always  
14 concern about losing the routine eye benefit because,  
15 again, as you know, we get to see all claims coming  
16 in. And when we took a peak, my team looked at the  
17 analytics and saw what a routine exam brought in, all  
18 the other services that were uncovered based on a  
19 routine exam was a lot.

20 So, hopefully that will stay in  
21 check. I think it's the same on the dental side as  
22 well.

23 DR. BURCHETT: Any other new  
24 business?

25 DR. COMPTON: Is it too soon to

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ask about the 1115 waiver?

MS. HUGHES: There was a hearing in October and we're still waiting on the decision of that.

DR. BURCHETT: If nothing else, I will entertain a motion to adjourn.

DR. UPCHURCH: I make a motion we adjourn.

DR. COMPTON: Second.

DR. BURCHETT: Thank you.

MEETING ADJOURNED