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

IN RE: OPTOMETRIC CARE TECHNICAL ADVISORY COMMITTEE MEETING

November 5, 2020
1:00 P.M.
(All Participants Appeared Via Zoom or Telephonically)

APPEARANCES

Matthew Burchett
CHAIR

James Sawyer
Steve Compton
Gary Upchurch
TAC MEMBER PRESENT

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APPEARANCES
(Continued)

Stephanie Bates
Sharley Hughes
Jessin Joseph
Lee Guice
MEDICAID SERVICES

(Court Reporter's Note) At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances?

AGENDA

Call to Order

Attendance/Introductions

Approval of February, 2020 TAC Minutes

- Who will be the Vision Providers be for the two new MCO's on January 1, 2021 for Molina and United Healthcare? Would DMS please provide contacts for the two MCOs so providers can reach out to start contracting?

- Will Wellcare, Aetna, & Anthem still offer an adult glasses add-on benefit in 2021? Any other MCO's plan to offer this benefit in 2021?
  - Frame Update Request (Dr. Upchurch)

- Dr. Upchurch – Questions on how to bill for patients that have Insurance & Presumptive Medicaid.

- In the future if the TAC would like to request additional vision codes be included in telehealth – how would this process work?

- What is Medicaid's policy on Durysta coverage (66030)?

- Dr. Compton would like to discuss issues with payment with Medicare/Medicaid crossovers.

- Discussion on billing 99 codes and 92 vision codes as medical.

- MPPR Portal Inquiry – Has DMS/OATS been in contact/ started discussions with the KY Board of Optometric Examiners to electronically transfer licenses into the MPPR portal so providers do not have to upload their paper form each year. Discussed in 2019 but not sure anything has taken place this year due to the pandemic?

Discuss future 2021 virtual Optometric TAC meeting dates? Day of week/time that works best?

DR. BURCHETT: We will call the meeting to order. The first order of business on the agenda there was attendance and introductions.

Normally, we go around the room and say hello and let everybody know where everybody is at and working from. We I assume have new people on since we're going to have some new MCOs. Is that true?

MS. BATES: If you want to go around, we can go around. I don't know who is on without going down through the list. Typically, what we have done is just move on and start the meeting.

DR. BURCHETT: Okay. That's fine.

MS. BATES: When people speak, just make sure you introduce yourself.

MS. HUGHES: Yes, please do that. If you have anything to say, just introduce yourself first.

DR. BURCHETT: Sounds good. Let me go ahead, then.

(INTRODUCTIONS)

DR. BURCHETT: Starting down the agenda, I'll ask the other TAC members, do you have any questions on the February TAC minutes; and if

not, I will entertain a motion to approve those.

DR. COMPTON: I so move, Mr. Chairman.

DR. UPCHURCH: Second.

DR. BURCHETT: Any other discussion on the minutes? Hearing none, we will have a vote. All those in favor of accepting them. All those opposed. So, we will accept the minutes.

Moving on to the meat of the agenda, then, I guess we'll just go item by item like we normally do.

The first item is who are we going to have as Vision Providers for the two new MCOs, and do we have any contact people for those so we can reach out to start contracting and credentialing with them? I think some of that was in the email Sharley might have sent earlier but if you have any other information, does anybody have any? That's the question, I guess.

MS. BATES: It looks like Angie sent over something to me and Sharley and said that March Vision is going to be both of their subcontractors but I will verify that for sure. That came from somewhere else, so, I like to verify my own information. I don't know if you're familiar with

them, though.

DR. BURCHETT: I am, yes. Thank you for that.

MS. BATES: We'll verify that and send it over to Sharley just to follow up to make sure we button it up.

DR. BURCHETT: Okay.

MS. HUGHES: And get you some contact information.

DR. BURCHETT: Yes. And I assume we're allowed to start contracting with them at this point?

MS. BATES: Yes.

DR. BURCHETT: Okay, because I don't think we've received anything from any of them personally to do that. So, I didn't know, and it could be because we're already in network with them. I don't know.

MS. BATES: Could be but we'll get some contact info. That way you're all good to go.

DR. BURCHETT: Okay. Sounds good. Steve, Gary, James, any other questions on that?

DR. COMPTON: That explains why

I keep getting correspondence from them, from March Vision.

DR. BURCHETT: If no other questions, then, we'll move on the next item which was will WellCare, Aetna and Anthem still offer the adult glasses in 2021, and do any of the others plan on it? And I think some of that information was sent as well.

MS. BATES: Yes. You should have a side-by-side that has an update for everybody.

DR. BURCHETT: Any questions on that, gentlemen?

MR. OWEN: This is Stuart from WellCare. If you have any questions of me, I'm here.

DR. LEVY: And Matt, we're still representing WellCare, Aetna and Humana. All three will have an adult value-added benefit.

MS. O'BRIEN: And this is Jean from Anthem and we will still have our benefit.

DR. BURCHETT: Okay.

MS. BATES: If you don't mind, I'm going to go ahead and plug open enrollment and the materials, and I'm just saying that because this is part of the materials, but what Sharley sent, any way that you all can get those out to people. We're

trying to get things in the hands of members since our communication with members was delayed this year. So, any help with that from you all would be great.

DR. BURCHETT: We can certainly do that because I'm sure our membership will want to know those facts as well. There's no problems there.

And I think Gary had something on frames he wanted to talk about a little bit real quick.

DR. UPCHURCH: Well, all I had was a question to see if there's any chance that we could get, for those of us who use the outside lab on our own, any update on the frame selections.

Both Avesis and Anthem, I know on both of those, especially under Avesis, I don't think we've had any update in several years now, or if it has been, it's been in a while. Children are choosing from the same frames every year.

DR. LEVY: Dr. Upchurch, it's Dan Levy again. We are in the process of updating our frame formulary. There's been a bit of a delay during COVID and also getting shipment in from China.

So, we are in the process with our partner lab, and I will keep you abreast of when that will be rolling out.

MS. GILBERTSON: Hi, Dr. Upchurch. I just wanted to let you know for Anthem numbers, also you will be seeing a refreshed frame kit; same kind of process I think that Avesis is having and going through getting all this updated, making sure that the frames that we had for a selection opportunity are available for all the members. So, you should be seeing that soon.

DR. UPCHURCH: Good.

DR. BURCHETT: Thank you all. Gary, if you want to keep going. I think the next one is your question as well.

DR. UPCHURCH: I'm just going to throw some questions out there because I really don't know. I've gotten a little bit of an explanation. I listened to something that Dinah sent me the other day from I think one of the legislators and Medicaid where they had a meeting.

We're having some issues with this Presumptive Medicaid in that it seems like anybody who applies for it gets it. And, so, we have a lot of people who are coming in that have Anthem Blue Cross and Blue Shield primary and, then, they have Presumptive Medicaid, then, they have EyeMed.

And at first, I reached out to

Medicaid and probably didn't understand exactly the answers that I got, but we know that always in the past, and I assume that it's still that way, the primary insurance if it's anything but Medicaid is always the payer of first resort. Medicaid is always the payer of last resort.

And, so, I guess this was a misunderstanding on my part because when they had, for example, say, they come in and they've got a specialist copay under their Anthem Blue Cross and Blue Shield of $45. I made the assumption which was a wrong assumption that Medicaid would pick up that copay. Evidently, that's not the case. They have to pay the copay.

However, we did on the ones that have a deductible with no copay, for example, they've got a $5,000 deductible but they don't have any copay. When Blue Cross and Blue Shield or Anthem, whatever you want to call it, denied that claim because of the deductible, then, it was flipped over to Medicaid and Medicaid was paying it, okay? So, I'm just trying to get some direction there.

And, then, we got into the situation - and I probably need to get my staff person to send those to Stephanie or someone - where

we sent in to the primary and the primary paid and, then, what was left over, we sent to Medicaid, but, then, Medicaid paid as a primary even though they had the EOB. So, we got paid primary from both places. We know that there's got to be a refund done.

It's just gotten a little bit sticky on my end and I don't really know. And even after I listened to the legislator in the Medicaid meeting the other day, I still didn't know when I got done and that's probably my ignorance, but I figure if I don't understand it, then, there's probably several others that don't, too.

MS. BATES: So, I'm going to say a couple of things and, then, I'll let Lee step in, too.

So, in Medicaid, we are always the payer of last resort regardless of the eligibility type, right? We're always the payer of last resort.

I would like to see those examples of where we overpaid you because the last thing we want is for you to have to deal with a big huge recoupment when you least expect it because you know it's probably coming. And Medicaid is slow, so, it will probably be like after you've forgotten it

and, so, I understand that.

So, if you will get that over, we'll look at that, but, Lee, do you want to describe a little bit about how presumptive eligibility works including the whole having other insurance and all of that?

MS. GUICE: Yes, I'd be happy to. Presumptive eligibility that we have given to everybody - we're allowed to cover so many people these days - was really for folks who don't have insurance. However, a lot of people had insurance or kept insurance and still had presumptive eligibility.

It's perfectly fine for you to bill their primary and then bill Medicaid. Medicaid should pay as they would have paid - for presumptive eligibility, they should have paid as they would have paid for a regular Medicaid claim. Any kind of Medicaid eligibility should pay the same.

Now, if they were a presumptively eligible and enrolled in an MCO, because outside of the COVID-19 pandemic, almost everyone who did have presumptive eligibility Medicaid was enrolled in an MCO.

So, depending on the time period when you saw these patients, and I suppose it

could have been they were enrolled in an MCO but probably not, Medicaid doesn't normally pay the extra copay, but certainly the deductible. If it's declined from the insurer, then, you submit the claim and we'll pay whatever Medicaid would have paid, you would pay the difference.

So, all of the presumptive eligibility individuals now, over 130,000 that we've added - actually, it's probably way more than that - well over 100,000 individuals that have been added during the pandemic, they should receive all the same benefits that anybody would receive in Medicaid, but, of course, we don't have those extra added benefits that the MCOs have.

Did I confuse you even more or give you any good explanation?

DR. UPCHURCH: I think I understand in that if they have a primary insurance, we collect the copay, go ahead and bill it to the insurance. Then, if there's anything left over, we can bill it to Medicaid. If it's not over what they would pay, then, they would still pay it, which it will be, so, they wouldn't.

But if they just have a deductible with no copay, then, once it's billed and

denied, then, we can send it over to Medicaid and Medicaid will pay their allowables.

MS. GUICE: Exactly, the allowables. That was the phrase that I was trying to get to.

DR. UPCHURCH: This would also work - let me just muddy the water here a little. This would also work for someone who has, let's say, Anthem Blue Cross and Blue Shield. They also have EyeMed and they have Presumptive Medicaid and it's a child, okay?

So, they come in. It's a routine visit. So, we don't send it to Anthem Blue Cross and Blue Shield. Everything goes to EyeMed. We have to exhaust EyeMed, and I'm assuming they would have to pay for their copays with EyeMed.

Then, after that's done, if they broke that pair of glasses or if they had to have a second pair of glasses which EyeMed would not cover, then, we go to Presumptive Medicaid on that child.

MS. GUICE: Yes, sir.

DR. UPCHURCH: I think the water is clearing.

MS. BATES: I don't know. Don't

be quick to say that now, Dr. Upchurch. Medicaid is in the muddy waters.

MS. GUICE: Medicaid can be a little bit muddy sometimes.

DR. COMPTON: I have one more thing for clarification, too, along these lines. If I understood you correctly a minute ago, there is no adult eyeglass benefit under Presumptive Medicaid.

MS. GUICE: In fee-for-service Medicaid, there's no adult eyeglass benefit.

DR. COMPTON: When we called for an adult, we were told they had a benefit up to $150 and then we got denied.

MS. BATES: So, the presumptively eligible enrollees are in fee-for-service, not a managed care company. And in fee-for-service, which is just regular Medicaid, no MCO, there's not an adult eyeglass benefit.

DR. COMPTON: I understand that but there's some confusion with if I say EDS, is that - I call it old Medicaid.

MS. BATES: When you call to get an authorization?

DR. COMPTON: Because I got the wrong information in.

MS. BATES: Gotcha.

DR. COMPTON: Thank you.

MS. GUICE: So, I just want to try to find out who it was, who was giving the wrong information so we could do a little training.

DR. COMPTON: His name is Dale. That's all we know.

MS. GUICE: Okay. Thank you.

DR. UPCHURCH: That answered my questions, I think. Thank you very much.

DR. BURCHETT: I guess moving on, then, the next item is we would like to request additional vision codes be included or added for telehealth. What is the process that we would go through to request those codes and coverage for Medicaid?

MS. GUICE: I think that you should do a couple of things. Certainly it would be a good idea to make a recommendation to the MAC. If you would also send an email over to myself with the codes listed so that we can take a look at that and do some review, do a fiscal impact, etcetera.

DR. BURCHETT: Okay.

MS. GUICE: So that when you make the recommendation to the MAC, that we can have

some information ready to respond.

DR. BURCHETT: Okay.

MS. BATES: And I'll tell you, and I did this this morning, that we have obviously recognized that the telehealth benefit has been really good for everybody. And pre-pandemic, we would have been a little apprehensive about being wide open, but what we have found is that it has been really, really good for our members and we appreciate all of that.

And, so, while wee feel like we had a benefit that was already kind of really open compared to other states before the pandemic, it really was just that providers weren't utilizing telehealth as much and, then, providers were kind of forced into that.

So, you have done really well and have just really done well with that. And, so, what we're doing now is looking at all those things that were kind of expanded and all the options that weren't included in our original pre state of emergency regulations and seeing what the requests are that come in and what we want to include in those post state of emergency so that way we have even more access.

So, that's why we're asking for that to come in writing so we don't lose track of everything and we know what works and what doesn't.

DR. BURCHETT: Right. I think before with regular codes, our Board of Examiners had to approve them for us to use and, then, we brought it to you all to be added. So, I just wanted to make what the situation was. Thank you.

The next item would be policy for Durysta coverage or is there one?

MS. BATES: I believe Dr. Joseph is going to answer to that.

DR. JOSEPH: This is Jessin from Kentucky Medicaid. We can provide coverage. So, I understand that it's currently on the fee schedule under 66030, and I guess I'm coming to the table a little bit late.

So, could someone provide a little bit more context as to the coverage behind Durysta? Is it that coverage doesn't exist right now or it's not appropriate to run it through the fee schedule and it needs to be set up through the Physician Administered Drug List because we do have a few options. I just need to make sure that I understand the question a little bit better.

DR. COMPTON: I'm the one that put it on here but you're----

DR. BURCHETT: No. Go ahead, Steve. I was getting ready to say I think that was yours.

DR. COMPTON: It is. Durysta is new. It's a glaucoma medicine that is injected into the anterior chamber of the eye. There's a CPT code and a J code - is that right - a J code that goes along with it.

DR. LEVY: That's correct.

DR. COMPTON: Of course, it's not a first line. It's not a medicine or a procedure you would do right off the bat but it's also a fairly expensive procedure and it's good for those that are noncompliant or those that are on multiple medications and their tear film is all beat up.

I don't know if there's coverage or how you go about since it's new getting it on the formulary.

DR. JOSEPH: Okay. I think I understand. We're just trying to figure out the best approach here. I think just from hearing that alone, because it's a specialty product, something that the patient needs to be ready to have it and the provider

needs to be comfortable with that patient, I think that it makes the most sense to add this product to our Physician Administered Drug List and, therefore, providers would use J codes to submit claims for the use of the product.

I'm not entirely sure how familiar everyone is with that but we can definitely kind of give some guidance in terms of how we bill using J codes, bill using the Physician Administered Drug List itself and we can add the product along with its associated J code because it looks like it wasn't approved until 10/1 of 2020.

DR. COMPTON: Right. It's new.

DR. JOSEPH: Got it. And it takes some time to get it into our system. We usually try to get it within three months of CMS giving the go-ahead. And, so, I know it's on our next round to review. So, we'll make sure that we do review it and look to add it for our next round.

DR. COMPTON: Great. Thank you.

DR. BURCHETT: And go ahead, Steve. I think the next one is yours as well.

DR. COMPTON: Cindy is sitting here. I don't know how many times it has happened, but Medicare/Medicaid crossovers. We've had a

patient that's, I don't know, fairly young, maybe on disability and they've got Medicare and they've got a refractive diagnosis and, then, we bill it for Medicare and they deny it, as they should. Then it crosses over to DMS and then it's denied.

And just to make everybody laughed, we called about it - I don't know who you talked to that day - anyway, they told us we should lower our fees.

So, I don't know how that makes any sense, but, anyway - Stephanie is laughing. At any rate, that should be paid by Medicaid with a refractive diagnosis. We've had, I don't know, two or three that aren't paid. It's a procedural thing, I'm sure.

MS. GUICE: Dr. Compton, if you could send me an email - this is Lee - send me an email with a couple of Medicaid ICMs so that we can look up those claims and do a little research.

DR. COMPTON: Okay. We'll try to do that. Do you want it to come from me or do you want it come from my billing manager?

MS. GUICE: Whoever has that information.

DR. COMPTON: She's going to be

a whole lot more prompt and better at that than I am.

MS. GUICE: What is that billing manager's name?

DR. COMPTON: Cindy Holman.

MS. GUICE: Just so I'll recognize it. That's all.

DR. COMPTON: Okay. Thank you.

DR. BURCHETT: The next item is maybe just a discussion on billing 99 codes and 92 vision codes as medical.

I know most of the MCOs use all of the vision for the 92 codes and we submit medical things through the 99 codes; but when we have situations with crossover claims and things like that, we find that when we use the 92 codes, that exhausts their vision benefit for the year as well.

So, if they have like Medicare with any of the MCOs, then, I think they won't have any vision coverage for the rest of the year if we go ahead and use that.

And I know we've tried to talk about the subject numerous times but is there any way that the 92 codes can come back out and be used medically as well and not diminish the benefit of the vision exam for those patients as well?

DR. LEVY: Matt, it's Dan again. I'd like to give an update, if I could, for WellCare, Aetna and Humana.

DR. BURCHETT: Okay.

DR. LEVY: We looked at this for quite some time now; and as you are well aware, we offer multiple benefits within the eye care programs that we administer. That is the routine or wellness exam with materials, as well as all medical and surgical for all taxonomies of eye care specialists in Kentucky.

So, what we have done over the past year because this has been an issue on the crossovers on the Medi/Medi, we have changed up our s systems and we are now diagnostic-driven, meaning that we would still want you to use the appropriate and applicable CPT code for services rendered; however, the system is now enhanced and reconfigured to pay out for services based on diagnosis which is new, which means you can use the 9200 codes for routine eye or wellness eye, as well as medical eye which was an issue for us and most in the past when you're configuring multiple benefits and trying to exhaust appropriately, and the 99 codes will still again be used for medical/surgical, but you now have

the ability based on diagnosis, and, again, hoping billing people utilize the appropriate identifier and pointer and modifier to bill this correctly or lay it out correctly. We have enhanced our systems to be able to do so so we can have provider ease and have a cleaner claim adjudication.

DR. BURCHETT: That sounds great. Let me just clarify so I can make sure I understand this.

So, a diabetic patient comes in and we're doing a diabetic eye exam. We bill 9200 appropriately for the medical for the diabetic eye exam. That doesn't exhaust their vision benefit.

So, if they come in later for their vision exam, we still bill the 92 with the myopia or whatever the vision code is. Okay.

DR. LEVY; That is correct. And we're ahead of it because we've implemented it already. We just really have been testing it, right? So, eventually, we will have an education on that and a provider communication, but we've launched this already in Kentucky and we wanted to make sure that it worked before we have a grande communication on it.

And we hope and the reason for

this is not only for provider ease but also payer ease because the less we have to deny, the less work there is. And it is not an easy task, and I know many, many organizations that offer multiple benefits tend to have the same challenges, but we put our energies into this this past year and hoping that this is really going to rectify a lot of the provider denial, claim denial I should say.

DR. BURCHETT: Okay. So, if I bill it that way this afternoon, it won't get denied, right?

DR. LEVY: I love that, Matt, and I appreciate that.

DR. BURCHETT: I'm just joking.

DR. LEVY: No. It really should. I mean, I have full confidence. My team has been testing this for some time. So, I would like to hear how it does work, but, yes, it should work. So, feel free to do that this afternoon.

DR. BURCHETT: Thank you, Dan. So, I guess I would ask Anthem if they have any updates or anything or they still kind of status quo on that issue?

DR. DAVIS: Dr. Burchett, we're still status quo on that issue at EyeQuest. We

recognize the 92 codes as medical codes, though. That should not be a problem anyway.

DR. BURCHETT: Right, but if we're----

DR. DAVIS: Like, the example you presented a moment ago probably is not a really good example, meaning you're not going to bring a patient in today who is a diabetic, an annual diabetic exam, let's say, asymptomatic, whatever, 9204, 92014, whatever. They're in there for their annual exam.

Your practice isn't going to bring them back a month later for another 92014 for a comprehensive exam again, I don't think, because I couldn't figure out what you would do differently on the first exam versus the subsequent exam.

DR. BURCHETT: Well, it depends. If they come in for their diabetic exam and they're having all kinds of trouble because their sugar is out of control, then, maybe later on in the year, we're bringing them back once it's under control to check vision and things like that.

DR. DAVIS: Right, and that should never be a problem anyway. Exactly.

DR. BURCHETT: Okay.

DR. LEVY: But a followup, I would think, John, would be a 99 code, wouldn't it, Matt? You saw the patient on the primary time. You know they're diabetic. They're having retinopathy and some challenges. You see them back. There's a shift in vision. I would assume you would have used the appropriate E&M code for that visit.

DR. BURCHETT: Right. Right.

DR. LEVY: Okay. I think that's what John is alluding to and I agree with him.

DR. BURCHETT: Oh, yeah. No, I do, too. And maybe I should have made my example clearer with you, Dan. I'm just saying when everything is stable, then, they come back because vision has fluctuated.

DR. DAVIS: Exactly, and those are common. They present to you with blurred vision and, then, instead of a minus three, you see, oh, you're a minus one. I know that's not going to stay there forever.

So, then, you say, look, you've got to give this thirty days. Get your sugar squared away, whatever, then come on back in.

And, then, we would hope you would want to bill a 99 code actually for that, maybe

92012 because of the situation you've presented which it's a difficult problem to handle because when we designate these 92 codes, we try to designate them as their "wellness" exam. We appreciate the 99's on the follow-ups, but, yeah, we still pay them anyway. We've changed any of those frequency issues with those.

DR. BURCHETT: Okay. Sounds good. I appreciate that, gentlemen. Any other questions on that, TAC members?

DR. UPCHURCH: On those particular diabetics that we're talking about, because we're going to have to do multiple refractions, those refractions can be billed more than once, correct?

DR. DAVIS: You have to because you're not going to - right. That's really one of the reasons they're coming back. I think our automatic frequency is three and the three sixty-five just as a random number and, then, after that, you know, those claims can always be reconsidered if someone is doing more than that, but that has not been a problem at all, the refractions, so you know. I haven't seen that.

We analyze that a lot, those

denials because we look for erroneous denials everywhere, in Kentucky in particular, and the refractioning hasn't been a problem because I think that three number is working out pretty well as sort of a, you know, again, a little bit arbitrary but reasonable maybe for patients as opposed to one really which was problematic, I think. We've changed that a long time ago.

DR. LEVY: And I don't recollect the LCD in Kentucky but I think ours is unlimited, but we do look at a 92015 quite a bit to make sure that it's being applied appropriately for care.

DR. DAVIS: Real quick. This is John Davis again. The Durysta situation, those intracameral injections, that's within the scope of optometry in Kentucky right now?

DR. COMPTON: Yes. We've already done one.

DR. LEVY: One?

DR. COMPTON: Well, it came out in October.

DR. LEVY: Because it's interesting. I see it on the vision fee schedule but I don't see it on the physician Kentucky fee schedule where I would think ophthalmology would be hit and

miss a lot greater and harder than optometry. So, I'm interested.

And, again, the gentleman, Dr. Joseph, that provided some of the insight on this, this is a high-level, new technology to be used when other services and care have been exhausted to no avail, no clinical outcome is how we will be looking at this on a clinical protocol and guideline. And, again, I speak for Avesis, Guardian, WellCare, Aetna and Humana.

DR. DAVIS: No doubt, that's going to be the same story with Anthem and EyeQuest. This is definitely not a first-line drug. The data shows a lot of complications potentially with this one. By the way, I see the 66030. I think it's been assigned a J code now, though.

DR. LEVY: It has, John.

MS. BATES: Just so you all know, I believe Dr. Joseph said he would go back and look, but we have Policy that will look at that, too, and, then, we'll definitely communicate out to our contracted MCOs with direction from the State.

DR. DAVIS: Thank you.

DR. BURCHETT: I guess moving forward, then, the last item on the list today, I

guess, has to do with getting the transfer of license renewals maybe quicker than having the provider do that themselves and I hadn't heard any updates on that. I know we talked about it a few times last year, but this point, is there anything that's----

MS. HUGHES: I did get an update, Dr. Burchett. Deputy Commissioner Cecil asked our Program Integrity folks and they said that they have not reached out yet, that it would probably be after the first of the year, and they were asking who would be a good contact. I don't know. Would that be Dinah Bevington?

DR. BURCHETT: For our Board of Examiners?

MS. HUGHES: Yes.

DR. BURCHETT: I think that would be their Executive Director Carson.

MS. BEVINGTON: It is. It's Carson Kerr.

MS. HUGHES: Do you have a phone number or an email address?

MS. BEVINGTON: I do. It's just carson.kerr@ky.gov.

MS. HUGHES: All right. I'll get that information to our Program Integrity folks

so that they can reach out to him.

MS. BATES: That sounds scary. She means Provider Enrollment. It's just that Provider Enrollment is under Program Integrity.

MS. HUGHES: I'm sorry. And I think I originally said Provider something and I changed it. So, yes.

DR. BURCHETT: Thanks for the update. We'll see if we can't get them talking and maybe have some movement there this coming year. That would be great.

Any of the TAC members have any other questions or concerns at this point? I don't think we do but maybe somebody has had something come up since last I talked with you all, or are you all in pretty good shape right now? Good.

I do have one quick question. It's more of a billing question for Dr. Levy if you wouldn't mind answering it for me or maybe trying to answer it.

My billing staff brought me this this morning and that's why, since I had you here, I thought I might ask. With Avesis, I know it's not general practice to do OCT and photos the same day, but one of my billing staff seems to think

that she had talked to somebody calling in about a claim and they told us that we could do that if there were different diagnoses.

DR. LEVY: No.

DR. BURCHETT: Okay. That's fine.

DR. LEVY: And if she has the person who she spoke to, please share that name because that's an education opportunity.

DR. BURCHETT: Right. Sure. I think it was the situation of a nerve fiber OCT for glaucoma and a photo for macular degeneration kind of thing, but that's fine. It was just a clarification.

DR. LEVY: Thanks.

DR. BURCHETT: Thank you, Dan. With that, it looks like 2021, we'll need to consider some dates, days of the week. Does Thursday still work best for the TAC members or would you prefer to switch to a different day?

DR. UPCHURCH: Thursday is good with me.

DR. COMPTON: Good with me.

DR. BURCHETT: Okay. Time of the day still good or would you rather do it 6:30 in the morning? The time of day is fine with me. I'm

just messing with you guys.

DR. DAVIS: Just an associated note, I'm really glad that you decided to have a virtual TAC meeting and, then, maybe on the go forward these virtual ones because I think these meetings are always meaningful to us.

From the MCO side of the table, it's good to hear from you all. So, I think having these virtuals is really going to be great if you keep going with it. I don't know what the plan is but I know you mentioned it here on the agenda.

DR. BURCHETT: Right.

DR. DAVIS: But thanks for doing this. We've been kind of missing them actually.

DR. BURCHETT: We were trying to wait it out to see if we could go in person and finally we just decided it was time to talk about some things. Everybody else is doing virtual meetings. Why not us, too, right?

DR. COMPTON: Maybe some sort of hybrid going forward. I think in-person is important occasionally.

DR. BURCHETT: For some things, I don't disagree with you, Steve, and maybe that's what we talk about and see what we can work out for

maybe every other one be virtual or a hybrid where some of us can be there and others could come in virtually if they want to. I'm open to any of those, to be honest.

MS. HUGHES: I think the good thing for now is knowing that we're scheduling them as a Zoom or a hybrid, they're not a special meeting. So, you are not held to what's just on the agenda. The other TACs have been excited that they weren't stuck with just what was listed on the agenda.

I can't remember right off the top of my head because it has been a long time since you all met. Were you all meeting every other month or quarterly?

DR. BURCHETT: It seemed like it was every other month, but it's not been long enough that I can remember, to be honest, Sharley.

MS. BATES: Quarterly.

MS. HUGHES: I'm just trying to get an idea of the time frame. I'm trying to figure out which dates these would be for 2021. It looks like maybe you were doing them like the middle month of the quarter, like February, May, August and November. So, the first Thursday afternoon of that month?

DR. BURCHETT: At this point, that is completely fine with me if it's fine with the rest of the TAC. And if that changes, can we get back to you if we have conflicts?

MS. HUGHES: Sure.

DR. BURCHETT: Let's tentatively, then, set it for the same time, first Thursday of those months. And in discussing it outside of here on the time frame for the other docs if that doesn't work, I'll get back to you, Sharley.

MS. HUGHES: Okay.

DR. COMPTON: We mentioned Dr. Munson at the beginning. I don't know that she is on the TAC anymore.

DR. BURCHETT: No. She has dropped off the TAC actually.

MS. HUGHES: Okay. Then, that could be my fault in maybe having changed my email address. Has she been replaced on the TAC?

DR. BURCHETT: We are currently looking.

MS. HUGHES: Okay. You all just let me know whenever she is. I'll send you an email out after the meeting with the exact dates; and if there's conflicts, you can let me know.

DR. BURCHETT: Sounds good.

MEETING ADJOURNED