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

IN RE: OPTOMETRIC TAC

HELD VIA ZOOM

DATE:
MAY 4, 2023
1:00 P.M.

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A T T E N D E E S :

Dr. Karoline Munson, Chair

Dr. Matt Burchett

Dr. Gary Upchurch

Dr. Steve Compton

Dr. James Sawyer

(and many more were on ZOOM)

1 DR. MUNSON: Okay. So I'm Dr. Munson.
2 Actually, Dr. Burchett is on the phone
3 call, but he is not feeling terribly well,
4 so he has asked me to go ahead and take the
5 helm today. So I'm glad that he could at
6 least join us, and I hope that you feel
7 better, Dr. Burchett.

8 So looking here to make sure we've got
9 our quorum. All right. So I think we are
10 good on that.

11 So the first move for us will be for
12 the approval of the minutes from the
13 previous meeting. So I will call for a
14 motion to approve those meeting minutes.

15 DR. UPCHURCH: I make a motion.

16 DR. COMPTON: Okay, go ahead. Steve
17 Compton. I'll second.

18 DR. MUNSON: Thank you, Dr. Upchurch, and
19 Dr. Compton, for the second.

20 Okay. So Item 4 on our agenda today
21 is some Old Business. So, DMS, you get the
22 floor pretty much our whole meeting today on
23 this old business. So I'm just going to go
24 ahead and pose these questions, and then
25 whomever from the Department has the best

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ability to answer them, just go ahead and chime in for us.

So does DMS have the no-show report to share with the TAC for the optometrists? I know we've had e-mail in the past, but I did not see one leading up to this meeting.

MS. BICKERS: Oh, he's logging in right now. Just one second.

Justin, have you gotten in yet?

MR. DEARINGER: Yes, thank you.

DR. MUNSON: Do you want me to repeat that question, then, so he can hear it?

MS. BICKERS: Yes, please.

DR. MUNSON: All right. So we are on No. 4 of our agenda under Old Business, and we are asking does DMS have the no-show report to share with the TAC for the optometrists? From last meeting we did have an update before our meeting, and I did not see one come through prior to this meeting.

MR. DEARINGER: No. I've still -- I've got that report pending. It's one that we have asked for. We are just waiting to get that information back. So I don't have that available today. We will have that

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available very soon.

And, again, just kind of a reminder, we are currently working on and hoping to have available soon -- I know it was scheduled for an April release date that got pushed back again. Hopefully, it's going to be sometime this month for the no-show portal or the no-show dashboard. That will be a public access website and it's going to be -- anybody will be able to access that dashboard to be able to look at each provider type, each county, break it down several different dimensions to be able to look at the no-show list and what reasons were given for those no-shows. So that hopefully will be done within the next month or so. I've been kind of expecting it for the last several months, to be honest, and it's been delayed a few times. It's in production with our IT contractors. It has been for a little while. The actual report that we asked for, I think they misinterpreted that information of us asking for an update on the actual no-show dashboard. So we have not received that

1 yet. We have corrected that to let them
2 know that we just needed a no-show for
3 optometry to get that information to this
4 TAC, so they should be sending that pretty
5 soon.

6 DR. MUNSON: And then how will that be
7 distributed? Just via e-mail to us on the
8 TAC?

9 MR. DEARINGER: Right. I will send that to
10 our staff that does the Technical Advisory
11 Committees and they will e-mail each TAC
12 member.

13 DR. MUNSON: Perfect. Okay, great. Thank
14 you.

15 And then next for DMS, has there been
16 any update on the Kentucky Board of
17 Optometric Examiners electronically sending
18 licenses to DMS?

19 MS. DUDINSKIE: Hello, this is Jennifer
20 Dudinskie for Program Integrity. So as of
21 February the 13th -- that was the last
22 contact we had with Carson Kerr -- he
23 stated there were still issues with the old
24 system and that it was a holdup on their
25 side. I had staff reach back out last

1 week, and there has been no response from
2 their office at this time. That is all I
3 have.

4 Any question, comments on that
5 portion? I have the next portion, too, on
6 the updated license piece. Okay. The next
7 question -- I hope you-all can hear me. I'm
8 getting messages that my internet is
9 unstable.

10 So we do have 163 optometrists who
11 have not updated their license. So
12 typically we have a notice that's issued 30
13 days prior to give -- send a notification
14 that provider you need to do this. I just
15 found out this morning that for whatever
16 reason that failed and that notification
17 didn't go out. So I requested that they
18 send a notification out today to those
19 optometrists. As of noon that should have
20 been issued, so, you know, just to give a
21 little extra notification out there for
22 those optometrists to update their license.

23 Any other questions for me?

24 DR. MUNSON: Not on that. Thank you.

25 MS. DUDINSKIE: Uh-huh (affirmative).

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Sure.

DR. MUNSON: So moving along, we are continuing our discussion with the 2023 New Medicaid vision material benefit for adults and children. So first and foremost, is there any update on the CMS approval on these new enhanced benefits?

MS. LEE: Hello, this is Lisa Lee. I'm the Commissioner for the Department of Medicaid Services. We are continuing to work with CMS regarding those benefits. We had a few questions regarding responding to those and we are awaiting their approval.

DR. MUNSON: Okay. Have they given you any timeline on that?

MS. LEE: They have not given us a timeline right now.

DR. MUNSON: Okay, thank you.

And then if we could discuss the answers that we received from the Optometric TAC's recommendation to the MAC. And so I may I -- may have Sarah, if you're on here or Dinah, chime in with that so we can maybe be a little more specific with what we are asking DMS to clarify. That's what happens

1 when you put somebody in charge of a meeting
2 like two hours before it starts.
3 MS. BEVINGTON: Dr. Munson --
4 DR. MUNSON: I can hear you a little bit.
5 MS. BEVINGTON: Dr. Munson, this is Dinah.
6 Can you hear me?
7 DR. MUNSON: Yeah. Yeah, I can. You're
8 good now.
9 MS. BEVINGTON: Yeah. So the Optometric
10 TAC, as you know, is a group devoted to
11 submit some recommendations to the MAC.
12 Those recommendations were received and we
13 received a response from the MAC. I don't
14 know if perhaps this is included on the
15 agenda just to make sure that all of the
16 TACs members know what response was
17 received. I'm happy to go through that if
18 there's any additional questions. We don't
19 have any additional questions here at our
20 office. I think this was just included
21 just as a follow-up because last time we
22 met we had not heard back, or we had voted
23 to submit them and we had not heard back
24 from our recommendations, but now we have
25 and I believe everyone on the TAC has heard

1 that, has gotten that response, but I don't
2 know if any other members wanted to ask
3 questions about that.

4 DR. MUNSON: So do we have any other of our
5 TAC members, Dr. Compton, Dr. Sawyer,
6 Dr. Upchurch, Dr. Burchett -- anybody have
7 any questions on what was submitted back?

8 DR. COMPTON: Dr. Munson, I was a little
9 confused, especially on the
10 medically-necessary contact lenses for
11 children along with eyewear. Hasn't that
12 been a benefit all along? Haven't we
13 always been able to fit medically-necessary
14 contacts on children?

15 DR. MUNSON: I believe that's correct.

16 DR. COMPTON: The response was that the
17 Department would need what numbers that
18 would affect, but they are already doing
19 it, so I wasn't real clear as to what
20 everybody needs to know about that.

21 MS. LEE: This is Lisa. Hi, Dr. Compton.

22 So our children's benefit, you're
23 correct, we could always do contact lenses
24 through the EPSDT. That's the Early
25 Periodic Screening, Diagnostic, and

1 Treatment program or benefit. Those
2 services could always be performed. So in
3 the event that anything needs to be provided
4 to children over and above that benefit, it
5 just, you know, needs to be through the
6 EPSDT benefit. We -- the language I think
7 may have been -- with that may have been
8 just a little bit confusing. We didn't need
9 to know the number for children so much as
10 we would have the adults, so I hope that we
11 clarified that answer. I think that there
12 were a couple of responses to those -- to
13 those recommendations and I hope that's been
14 clarified. But that has always been a
15 benefited for children.

16 DR. COMPTON: Commissioner, thanks. I
17 think there may be another disconnect that
18 we all need to be on the same page when we
19 talk about medically-necessary contact
20 lenses, or I'm using the term luxury
21 contact lenses, those folks that just want
22 contact lenses because they don't want to
23 wear glasses or what have you. There may
24 be some confusion between all the parties
25 involved and all these expanded benefits as

1 to what is what, so to speak. So just to
2 me it's like, you know, maybe we are not
3 all on the same page, but that could just
4 be me.

5 MS. LEE: And I think maybe that's what the
6 response was trying to state, that the
7 contact lenses should be medically
8 necessary. But I agree that we need to go
9 back and look at the language to make sure
10 that we clear up any confusion related to
11 the coverage of the services that we are
12 providing. I believe the expanded services
13 we -- everything in Medicaid, of course,
14 has to be medically necessary for us to
15 deliver those services, but I believe that
16 the intent is that we will cover contacts
17 and/or glasses for individuals regarding
18 their vision needs, that we would cover
19 them and they have to be medically
20 necessary, of course, the contact lenses.

21 So if somebody needs -- for example,
22 somebody needs correction, vision
23 correction, we would think that they could
24 get either glasses or contact lenses, but
25 I'll have to defer back to Justin and to see

1 if that was the intent in the regulation,
2 that anyone could get either contact lenses
3 or glasses, or was there special criteria
4 for contact lenses.

5 MR. DEARINGER: This is Justin Dearing.
6 Thank you, Commissioner.

7 No, you are absolutely correct, the
8 intent was -- has always been and currently
9 is, even in the new reiteration, that
10 contact lenses are for medical necessity
11 only. And we spoke with multiple providers
12 when we initially created the administrative
13 regulations. They talked about instances
14 where contact lenses were the preferred
15 choice for certain instances and certain
16 indications, and that's what we were trying
17 to do was to give the provider the choice of
18 exactly what type of corrective prescription
19 that that individual needed based on that
20 provider's assessment and that individual's
21 needs. And so that's why it says they can
22 have one or the other, and it is, you know,
23 basically left to the discretion of the
24 clinician that's prescribing those lenses.

25 If there's, you know, any thought that

1 clinicians in the state of Kentucky wouldn't
2 be capable of making some of those choices
3 or things like that, we could talk about
4 that maybe with the Board. That might be a
5 better discussion for them. But for us on
6 our fee schedule, we only open that up to
7 allow for prescribers -- clinicians,
8 prescribers to prescribe exactly what they
9 felt necessary for their individual patients
10 based on their analysis and their expertise.
11 And we show that on the fee schedule as well
12 as the administrative regulation.

13 MS. LEE: And, for example, we would not
14 cover contact lenses if someone did not
15 have -- did not need vision correction and
16 they just, for example, wanted to change
17 the color of their eyes. Those contacts
18 would definitely not be covered. That's an
19 example of contact lenses that would not be
20 medically necessary for individuals.

21 DR. MUNSON: So let me -- let me just make
22 sure -- this is just Dr. Munson -- that
23 when you talk about the medical necessity,
24 it is actually defined by either their
25 clinical diagnosis or their prescription.

1 So for someone who is, you know, just --
2 you are wearing reading glasses, so let's
3 say they just want to have contacts so they
4 can see to read, then that is not what it
5 falls into medically necessary.

6 Now, if they are very, very
7 nearsighted -- I believe the statute is
8 minus eight and above -- then someone that
9 falls into that would be considered
10 medically necessary. So it is the same --

11 MS. LEE: Yes, that's correct.

12 DR. MUNSON: So I want to make sure that
13 this isn't any different than what we have
14 already been following for children.

15 MS. LEE: That is correct.

16 DR. MUNSON: Okay, perfect. Thank you.

17 DR. COMPTON: That clears up the confusion.

18 DR. MUNSON: Absolutely. And then will
19 that -- is that already now reflected on
20 the new vision fee schedule, that it is
21 medically necessary only for the
22 reimbursement for the contact lenses?

23 MS. LEE: Yes, I believe that is -- it's
24 definitely spelled out in the regulation.

25 DR. MUNSON: Okay. And then is that going

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to be included on the fee schedule as well,
annotated on that, or just in the
regulation?

MS. LEE: We can -- we can go back and look
at the fee schedule and see if it's
annotated on there. If not, we could -- we
could add that if the TAC thinks that's
something that would be useful for the rest
of the population.

DR. MUNSON: It would just -- it would make
it easier to keep that kind of clean that
way. Perfect. Thank you. And then -- go
ahead.

MS. BEVINGTON: I'm sorry, one quick thing.
So what we have heard from a number of
providers is that the patient population
believes that they have a choice between
glasses or contact lenses. And then when
you pull the vision fee schedule, that's
the language that is utilized, it's a
choice between contact lenses or glasses.
The medically-necessary language to include
on that vision fee schedule and any
communication out to patients would be very
helpful to help clarify that, because our

1 providers are on the front lines having to
2 explain that not everyone gets contact
3 lenses just because they prefer to have
4 that as their method of vision correction.
5 MS. LEE: Okay. So would it be helpful
6 then if the Department drafted up --
7 drafted a letter maybe, or some sort of a
8 communication, and let the TAC review it to
9 see if we could clear up some of this
10 confusion, and are you saying you think it
11 would be better for the members and the
12 providers, or both?

13 MS. BEVINGTON: Absolutely, for both as
14 well. Yeah.

15 MS. KLINGELHOFER: This is March Vision.
16 This is Tyania from March Vision. We are
17 using the language, elective contact
18 lenses. And just recently we have been
19 guided to tell our providers that it's
20 eight units covered, and it's glasses or
21 contacts, and that is what's specific on
22 the benefits. So we -- we do need some
23 clarify. Members need clarity, providers
24 need clarity. This is just causing a bunch
25 of chaos for us on the MCO side, and we're

1 in May. Let's just say we're -- you know,
2 we are halfway through the year with these
3 new benefits.

4 DR. DAVIS: This is John Davis from
5 EyeQuest. I want to reiterate that
6 statement that it's so confusing. Maybe I
7 can ask just one maybe simple case in
8 point. Maybe -- Dr. Munson, let's assume
9 the patient comes into your office and they
10 are, whatever, minus 1.25 sphere; right?
11 They are 12 years old. They are at 1.25
12 spheres. They maybe have a little cell,
13 whatever. It doesn't matter. Right? So
14 they see with glasses 20/15 correctable.
15 They say, no, I don't want glasses this
16 time; I'd rather have contact lenses. Is
17 it our understanding that that patient now
18 is allowed to have contact lenses instead
19 of glasses at that visit? Let's assume,
20 right, you don't have a contraindication to
21 it. You just say, fine, that's what they
22 want. Would that be part of the criteria
23 for when we would cover contact lenses for
24 the kids, do you think, based on your
25 understanding?

1 DR. MUNSON: All right. So you are asking
2 me based on my understanding in the
3 clinical setting. No, because the
4 regulations are written that for them to be
5 medically-necessary contacts, that child
6 needs to be a minus eight or higher. So,
7 yes, clinically they could get them, but
8 would the coverage come from them
9 personally? Yes. Would it come from DMS?
10 No.

11 And I'll ask Commissioner Lee if I'm
12 interpreting that correctly, but I believe
13 that is.

14 MS. LEE: I think I need to take this back
15 to some of our policy folks and our medical
16 director to make sure. I've been taking
17 notes and got the information that you-all
18 have asked. But I want to go back and just
19 clarify, are we now saying that individuals
20 can have contacts or glasses, and that if
21 that's the case, then we need to clarify
22 that, or are we saying that, no, they can
23 only get contact lenses in the event that
24 it meets medical-necessity criteria and
25 here would be -- and here is the criteria.

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MS. ALLEN: This is Nicole with Avesis --
MR. DEARINGER: I just want to say that the way that we currently interpret it in our regulation, at least in the last one that was filed and the current regulation that was filed, that it would have to meet medical necessity. We have said that in each regulation. In both places we have said that specifically that it had to meet medical necessity. And medical necessity would be if the clinician decided that it was medically necessary for that individual to have contacts.

It doesn't have to specifically be a medical issue, you know. It could be that the -- you know, maybe a child has some form of autism where they won't keep the glasses on their face and they decide that contacts are a better solution. There are a multitude of different areas and reasons why a clinician may choose to describe -- or prescribe medical contacts over glasses; however, it has to be a medical necessity and medically necessary for them to be able to do that. And I think we state that in

1 the regulation and in the previous
2 regulation as well.

3 MS. LEE: Thanks, Justin. I still think
4 there is some confusion based on the
5 conversation that we are having. There
6 still seems to be -- and I think Nicole
7 from Avesis -- were you going to say
8 something?

9 MS. ALLEN: Commissioner Lee, thank you. I
10 just wanted to confirm that for Humana, for
11 Aetna, and also for WellCare, based upon
12 the 4/12 care revisions we reinstated the
13 medically-necessary criteria. So for the
14 adults and for children, contact lenses are
15 not in lieu of eyeglasses. They are
16 covered under medical necessity. We are in
17 the process of updating our plan sheets for
18 the providers, so that will -- that will be
19 released very shortly, or very soon, I
20 should say. Thank you.

21 MS. LEE: And I think, Dr. Munson, that
22 was -- what Nicole just said is your
23 understanding, too, that contact lenses are
24 not covered in lieu of, but must meet
25 medical necessity.

1 DR. MUNSON: Correct. And this is
2 discussions in previous times with the TAC,
3 and if the TAC members would like to chime
4 in -- we had actually gone over this in
5 detail in a special-called meeting, because
6 initially I don't believe, and the other
7 TAC members can bring their recollection,
8 but I don't believe initially when this was
9 presented that it was just contact lenses.
10 There was no dialogue in there about
11 medical necessity at all, and that was
12 something that we brought. That was a
13 recommendation that we brought to the MAC
14 that it was medically necessary only.

15 It was already there in statute for
16 children, but when this expanded benefit
17 came out that it was expanded to adults, but
18 it kind of became a free-for-all, and I feel
19 like that's also what some of the MCOs on
20 the call are talking about, is it has been
21 kind of a moving target because that medical
22 necessity wasn't -- wasn't hammered out and
23 wasn't written out for people to understand.
24 And in addition, Justin's scenario -- and I
25 understand that you are not a doctor, but

1 I -- I almost cannot imagine getting a
2 contact lens in an autistic child's eye that
3 will not wear glasses. I can't imagine them
4 letting us come and do that.

5 But when we talk about medical
6 necessity, that is already defined in
7 statute. I've been in practice 22 years.
8 It has been in Medicaid to tell us when that
9 is allowed and when it is not allowed. So
10 it's not like I can say, oh, my, minus four,
11 plays football, and he could potentially get
12 hurt by having his glasses on under his
13 helmet, so I'm going to deem that medically
14 necessary. I as a practitioner don't have
15 the leeway. The Department of Medicaid has
16 told us what parameters is medically
17 necessary and what is not. And so that is
18 not something we need to reinvent the wheel.
19 The Department has already done that. We
20 just need to make sure that it is referenced
21 across the board, and we as practitioners
22 need to know, so we know which direction we
23 are going, and also the recipients need to
24 understand what benefits they do or don't
25 have. So I think Dr. Upchurch has had

1 several instances of this, so I'm going to
2 let him kind of give his background on it.
3 DR. UPCHURCH: Well, our understanding
4 in -- and this has been horrible. I've
5 talked with all the MCOs. They are in a
6 bad position. I've talked to providers,
7 multiple providers. We are all in the
8 position where these patients are coming in
9 and their understanding is, is that they
10 can choose either contact lenses or they
11 can choose glasses. And, you know, we are
12 put on the front line and it's difficult.

13 So we've got some MCOs that -- several
14 MCOs that are providing that, several that
15 are not. And at this point I'm in total
16 agreement with the TAC. We have guidelines,
17 Medicaid does, on what is medically
18 necessary. And I've been -- I've been
19 going -- you know, I've been going against
20 the grain on that because we have been told,
21 or we have been implied that we could -- you
22 know, people could get contacts. I'm all
23 for making this plain that what exactly the
24 stipulations are, and also getting that
25 information to the patients, because it's --

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it's killing us on the front line.

And to put contact lenses on children, especially when you're saying you are providing a year's supply, but you're not; you're providing one unit per eye, which is only one box, which is six lenses per eye, that's only six months' supply at maximum, then we are looking at potential major problems down the road as those people overwear those type of lenses.

I hope that helps. I hope that's what you were after, Karoline. I don't know.

DR. MUNSON: Yeah. Thank you, Dr. Upchurch.

MS. LEE: That helps me tremendously, too. And I think that there is a bigger conversation that needs to be had. I definitely appreciate this conversation. I understand the confusion. I understand what action we need to take and to get some clarity. So I will -- I will take this back to my medical team, to my policy, have a discussion. And what I'm hearing from this -- from the TAC is that we already have the medical-necessity criteria. If

1 the intent of the Department is to only
2 apply medical-necessity criteria to contact
3 lenses, we already have that in place. If
4 the intent is to allow contacts in lieu of,
5 we need to do some communication and some
6 outreach to our provider community and our
7 members, and our managed care
8 organizations.

9 DR. UPCHURCH: Agreed.

10 MS. LEE: Thank you-all so much. This has
11 been a great conversation and glad that I
12 could join today, and hope to be able to
13 join as many of these as I can in the
14 future of the TAC meetings because always
15 good information and good conversation.

16 DR. MUNSON: Great.

17 MS. BEVINGTON: In the meantime, you know,
18 are we sticking to the medically
19 necessary --

20 MS. LEE: Well, and it sounds like to me
21 that there's providers that are sticking to
22 the medical-necessity criteria and
23 providers that are not. So I think in the
24 meantime I would stick to the medical --
25 well, because everything in Medicaid has to

1 be medically necessary, so I would -- I
2 would recommend sticking to the
3 medical-necessity criteria that's outlined
4 in the regulation.

5 MS. BEVINGTON: Okay. Thank you.

6 MR. IRBY: And, Commissioner Lee, this is
7 Greg from UHC. And for our organization, I
8 think the regulations are pretty clear that
9 contact lenses must be medically necessary.
10 The regs specifically say in 631, it says
11 that these are not covered unless they meet
12 the 632 guidelines, which require the
13 medical necessity. So I'm not sure how all
14 the MCOs are handling this, but we are
15 handling it in alignment with the current
16 regs. So if that question were posed to us
17 as an MCO, the answer is yes, we have to
18 have medical necessity. It is not a
19 in-lieu-of benefit.

20 MS. LEE: Thank you, Greg.

21 DR. MUNSON: Do any of the other members of
22 the TAC committee have any other comments
23 on the contact lens issue?

24 DR. COMPTON: Other than just we are here
25 to help, so just, you know, please run it

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by us and we will maybe save everybody a lot of heartache.
DR. MUNSON: Okay. So next question was the discussion on balance billing with the -- anything that people get, and this is both children and adults. Is that something that is going to be allowed? I mean, I've had this question even this week. And so that would be something that if we could get some clarity on whether or not that would be allowed, that would be great.

MS. LEE: The federal rules do not allow balance billing of Medicaid members, so...

DR. MUNSON: And so this is kind of where this is hard for us to thread the needle. So previously some of the MCOs have been generous enough to offer a value-added benefit of glasses, and in that value-added benefit if the patient chose to get something different, they were allowed to have an upgrade. And so if this benefit now flips to a benefit for all that is coming from DMS, they will not be allowed to do any of that balance billing from this

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point further?

MS. LEE: That is correct, because it was not a covered benefit before, patients would have had -- and in the event that the Medicaid MCOs did not offer that benefit, the patients would have had to pay for that service themselves. Now that it is a covered service in the Medicaid program, it has to be -- we have to have -- the rules have to apply equally to everyone, and there would be no balance billing in the program.

DR. MUNSON: Okay. And then the last question refers to the contact lens fitting fee, which is code 92310.

In our last meeting DMS said that there would not be a limit on the use of that code. So some of the MCOs are not covering the contact lens fitting and others have confirmed that they will only pay for one fitting during the year. So if DMS has not put a limit on the vision Medicaid fee schedule, can the MCOs set their own limits and not follow the fee schedule limits?

MS. LEE: If the Medicaid fee schedule does

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have a limit, the MCOs have to adhere to that limit. They can exceed that limit, but they could not reduce that limit.

DR. MUNSON: So if it does not have a limit on it, they cannot reduce that; is that what you're saying?

MS. LEE: If it does not have a limit, if we have no limits in place, then there's no limit, and I would -- I would look to see if it's something that -- you know, how many -- how many contact lens fittings a year would be appropriate. Is it something that the Department should consider a limit on, is what I would ask the TAC.

DR. MUNSON: So that really depends on what you're fitting. I mean, that -- and I'll let Dr. Upchurch speak to it, too, because specialty fittings are a different animal altogether.

DR. UPCHURCH: Well, in my office basic contact lens fitting, I cover it with just the one visit. That would not be a problem, but that's at a minimal charge. Then when you go up to lenses such as toric lenses, astigmatism lenses, you go up to

1 gas permeable lenses, you go up to bifocal
2 contact lenses, typically those are going
3 to require several visits, and our charge
4 goes up to the private pay patient
5 accordingly. And so one charge of 92310
6 per year would not even come close on a gas
7 permeable bitoric contact lens, or, you
8 know, a gas perm bifocal lens. We would --
9 we would essentially lose our shirts on
10 that.

11 MS. LEE: I think that there was a
12 conversation prior to this that talked
13 about the type of lenses that Medicaid
14 would cover and there was a -- there was
15 some concern about the gas permeable. For
16 example, there was some talk of concerns
17 about the different types of lenses, and a
18 recommendation was made that we only -- I
19 think that the regulation right now -- I
20 know the regulation says that we cover
21 daily lenses rather than the gas permeable
22 and the different types, the hard lenses.

23 DR. UPCHURCH: Well --

24 DR. MUNSON: If you don't mind here --

25 Dr. Upchurch, I'm going to jump in here

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real quick.

So, Commissioner Lee, this is really -- you're really hitting the nail on the head, and I think it may be a good idea to review the December meeting, the emergency meeting that the TAC called, because you will hear a lot of this conversation and understand where some of the miscommunication or just misunderstandings are coming from.

So when you go back to talking about a medically-necessary contact lens, and I'll use keratoconus for example, probably the number one reason we would use a gas permeable lens. That is not something that can be corrected. It's a disease of the front part of the eye. You cannot correct it very well with glasses. You can only get the best visual acuity with a gas permeable contact lens. That is a medically-necessary specific reason that DMS would cover contact lenses.

When we were told initially, when this was brought to us, it was contacts for everybody, kids, adults, everybody. There

1 was medically-necessary not in the
2 discussion at all, and that was where our
3 frustration came in, because it was approved
4 for one unit. When we initially had our
5 discussion, one unit meant one soft contact
6 lens per eye per year. Again, I've been in
7 practice 22 years. I have not dealt with
8 these lenses since I was a minor working in
9 my doctor's office in high school. That is
10 how antiquated that technology is. So we
11 tried to bring this to DMS, and that was
12 something that we tried to have that
13 conversation that those lenses are not
14 standard of care. Those lenses are going to
15 end up in worse health for the front part of
16 the eyes for the patients, and honestly
17 ultimately more cost to DMS for visits to
18 our office. So that discussion is all on,
19 as Dr. Compton refers to them, luxury
20 lenses, the I-want-contact-lenses, not
21 I-need-contact-lenses.

22 So the materials that we're using when
23 we talk about an I-need-contact-lenses are
24 completely different, they are much more
25 complex, they require a lot more chair time,

1 a lot more visits, and that's where the
2 multiple use of that fitting fee code that
3 Dr. Upchurch was explaining comes into play.
4 And so there may be a daily lens that is
5 necessary for someone in some -- in some
6 respects, but more than likely there are
7 very specialty lenses that we're talking
8 about for someone that is having -- that
9 actually has a disease of the eye. Somebody
10 who is just incredibly nearsighted that
11 literally can't see past, you know, two
12 inches in front of their eyes and they have
13 contact lenses, then, yes, daily lenses
14 would appropriate for them to maintain the
15 health of their eyes.

16 So this is a very nuanced conversation
17 and this is just pointing to the reason why
18 we as an Optometric TAC, since we are the
19 doctors, this is our wheelhouse, we can
20 provide all these answers, where folks at
21 DMS, it's just that's not their thing. They
22 didn't go to school for it. So it's very
23 hard to work through these nuances if it's
24 not something that you are incredibly
25 familiar with.

1 So I didn't mean to jump right in
2 there, Dr. Upchurch, but I feel like this
3 really points to why this has been such a
4 conundrum for all of us.

5 DR. UPCHURCH: You're good.

6 MS. LEE: I appreciate that. Dr. Munson, I
7 appreciate that. I will go back and review
8 those December emergency meeting minutes,
9 and I think we've got -- the regulations
10 were refiled on April the 12th. They will
11 be up for review, reg review, on May the
12 9th. That's next Tuesday at 1:00. So we
13 will talking about the regulations with reg
14 review.

15 And, again, I think this is some good
16 conversation. I think our intent -- of
17 course, we do want to focus on services that
18 are going to help our Medicaid members
19 improve their vision, improve their sight.
20 I think that is a first step. I think we
21 have some more conversations to go and some
22 more tweaks to make before we get it just
23 right. But I do think it's vitally
24 important for our Medicaid members, our
25 adults, to receive glasses or contact lenses

1 in order to correct their vision so that
2 they can, number one, be able to function in
3 society, but, you know, help them get back
4 into the workforce so that they can see as
5 they go forward.

6 I think that we have -- you know, from
7 some of the stats that I've been looking at
8 maybe -- you know, preliminary maybe over
9 50,000 individuals who have received
10 glasses. Not the contact lenses. Glasses.
11 I've seen very view contact lenses. I think
12 that's a large number and I think helping
13 these individuals be able to see and regain
14 some freedom in their life is very
15 important.

16 I so appreciate this TAC, and I do
17 look forward to conversations on how we can
18 clear up some of this confusion and do
19 what's right by our Medicaid members and our
20 providers. So I think, you know,
21 Dr. Munson, your conversation that you
22 just -- very on spot and appreciate your
23 candor. You are correct that the
24 individuals here at Medicaid, we don't have
25 the expertise that you have, and we will be

1 looking to you, to this TAC, to help us as
2 we move forward.

3 DR. MUNSON: So we have 50,000 covered
4 lives that received glasses since January
5 with this expanded benefits?

6 MS. LEE: For adults. If the -- if the
7 information that I am looking at, if I am
8 interpreting it correctly, that's about
9 57 -- I can't -- 50 -- I can give you the
10 specific code. Let's see, the code that
11 I'm looking at, it's V2100 to V2399. Those
12 are glasses, 58,000 individuals.

13 DR. MUNSON: And that's just in the adult
14 component of it?

15 MS. LEE: Just the adult since January.

16 DR. MUNSON: And that includes all the
17 codes within that or that's individual
18 lives?

19 MS. LEE: That's 58 individual lives.
20 62,173 services delivered to those 58,000.
21 And a little over \$1.5 million.

22 DR. MUNSON: Wow.

23 MS. LEE: So, you know, we do know that
24 there was a pent-up demand. And one of the
25 things that I talk about when I talk about

1 our Medicaid members, I talk about, you
2 know, the federal poverty level. We always
3 throw out that federal poverty level
4 number, and, you know, it's at 138 percent
5 of the federal poverty level and below, and
6 what does that really mean. You know, for
7 a family of four, some of the information
8 that I've looked at if you look at that
9 138, it's right around \$40,000 a year, and
10 the average cost to live in Kentucky is
11 over 42,000. So individuals -- the bulk of
12 these individuals that we are serving,
13 Medicaid members, you know, they're working
14 to put food on the table. And that 42,000
15 that I talked -- 40,000 is pre-tax. That's
16 before taxes are even taken out of their
17 income.

18 So having glasses is a luxury for some
19 of them and it shouldn't be a luxury. It
20 should be a benefit. They should be able to
21 see and to read and to drive. So I think
22 that 58,000 number is very telling about the
23 pent-up demand that was out there, the
24 individuals that did not have corrective
25 glasses that needed them. So, again, I

1 think that it's something that's totally
2 different. And we haven't covered glasses
3 before, but I think it's something that is
4 so necessary.

5 DR. COMPTON: Commissioner, it's
6 Dr. Compton. On the 58,000, or whatever
7 number you just quoted, you say it's V2100
8 through V- --

9 MS. LEE: 2399. It says lenses is what
10 I've got the description --

11 DR. COMPTON: Most of the times there's two
12 V codes filed per pair of glasses.

13 MS. LEE: So even if you halved it, it
14 would be about -- it would still be about
15 30,000 individuals. Now, there's another
16 V2020 --

17 DR. COMPTON: That's frames.

18 MS. LEE: -- that's 57,495 people.

19 DR. COMPTON: Then that would be accurate
20 because that's only billed once. I just
21 didn't want the wrong number getting out
22 there.

23 MS. LEE: Yeah. 57 -- V2020 is 57,495.
24 So, and I think that that's very telling
25 on, you know, the pent-up demand that was

1 out there for individuals who needed to be
2 able to see.

3 DR. COMPTON: It's a great, great benefit.
4 We just need to get everything -- get us
5 all on the same page.

6 MS. LEE: And I think we are getting
7 there, you know --

8 DR. COMPTON: Today's made a big -- a lot
9 of headway.

10 MS. LEE: I think we are getting there. I
11 think that, you know, it's really
12 important, and I always say that the
13 Medicaid program was created for the
14 member, but we can't take care of our
15 members if we don't take care of our
16 providers because you-all are the ones
17 seeing these individuals, you know, so very
18 vital to getting them the services they
19 need. But I was really -- I was a big wow
20 when I saw that number of glasses, of 57,
21 just since January, so...

22 DR. MUNSON: Absolutely. And that is -- I
23 mean, I will say for the MCOs that did
24 cover that as a value-added benefit, it
25 is -- I mean, at that point was wonderful

1 because for several years as a practitioner
2 I just had to say, oh, you turned 21, you
3 know, sorry, you don't get anything
4 anymore, or have the conversation with the
5 20-year-old to be like, you know, we got to
6 get this done before you turn 21. So the
7 MCOs that offered that as a value-added
8 benefit kind of cracked things open. But
9 this benefit is fantastic. It is
10 definitely something that I think can
11 change the lives of the people in the
12 Commonwealth.

13 I did get one question for you in the
14 chat and I'm just going to read it from
15 here. It's LeeAnn Ellis with March Vision,
16 and it's, "Question for DMS to take back
17 please: If there is no elective contact
18 lens benefit, then why does the current
19 revised 4/12/23 Kentucky Medicaid fee
20 schedule indicate that codes V2500,
21 et cetera show as available with 8 units?
22 It specifically states, 'Adults and children
23 may select eyeglasses or contact lenses per
24 year but not both.'"

25 MS. LEE: And I think this goes back to the

1 conversation we had about the medical
2 necessity that's in the regulation that's
3 not on the fee schedule to cross-reference,
4 so that's a very good question and
5 something that we are going to take back
6 and discuss.

7 DR. MUNSON: Okay. Excellent.

8 Now, does anyone on the TAC have any
9 other questions about the 2023 New Medicaid
10 vision material benefits?

11 DR. UPCHURCH: I just have a comment,
12 Karoline. I just want to say to Director
13 Lee how much I appreciate you, and you
14 probably don't remember me, but we worked
15 together so many years ago that you
16 probably don't even want me to mention it,
17 but I appreciate you and your team and you
18 listening to us and hearing us out on this,
19 because we on the front line, and the MCOs
20 right behind us, have sort of been in a
21 real predicament since this all came along.
22 So I just want you to know we don't mean to
23 cause you-all any problems, but we really
24 appreciate what you are trying to do for
25 the people of Kentucky, and I think we are

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on the right track here.

MS. LEE: I appreciate that, Dr. Church.
And I do remember you and I think -- I
can't even remember how long ago it was.

DR. UPCHURCH: You don't want me to say.

MS. LEE: It was a while.

DR. UPCHURCH: Yeah.

MS. LEE: But I have over, you know, 20
years' experience in the Medicaid program,
and Medicaid is a huge, huge program and
you know, our resources are -- you know,
just like many of you, our resources are
stretched to the limit. And sometimes when
we go down these paths of making changes to
the program, it's very difficult because
it's not just the Department and the TAC,
it's CMS has to be involved, you know,
other -- it's just, you know, our system
changes, different things.

And we do agree with you,
Dr. Upchurch, that we are going down the
right path. We've got a few bumps in the
road, but I think that we are going to get
those straightened out and do what's best
for our members and our providers as far as

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the vision services goes, and this has been a really good conversation today, I believe.

DR. UPCHURCH: Thank you. That's all I wanted to say, Karoline.

DR. MUNSON: Okay. Thanks, Dr. Upchurch.

Okay. Well, if we don't have any other questions on that part, then we will go ahead and move on. I believe Ms. Dudinskie already answered our question under New Business about our optometrists about updating their license.

And then the other general discussion, a couple of things -- I know that Avesis had some questions. Again, getting told to lead the meeting two hours before it starts, I don't have those. But I do have one to lead up to that that kind of does tie in, Commissioner Lee, with what you said about the contact lens fee, the 92310, if there's no limit on the fee schedule, then there's no limit of those codes. Our regular just 99 codes, so 99211, 99212, 99213, those do not have limits on the fee schedule, so are those also something that would not be limited from the coverage from the MCO

1 perspective?

2 MS. LEE: Would you say those codes again,
3 please? I'm sorry.

4 DR. MUNSON: So they do have -- excuse me.
5 They do have limits of two, which is 99211,
6 99212 and 99213. And so they have a limit
7 of two -- excuse me, I'm saying this
8 backwards. So what we are asking, and I
9 don't -- I don't know the correct direction
10 for this to go or how this request to come
11 through, but that's something -- like I
12 have a guy that comes in and gets a foreign
13 body in his eye. A 99213 would be very --
14 very correct to use for follow-ups. Well,
15 if they don't follow my directions, they
16 don't get their eyedrops, and I have to see
17 them two or three times, I actually can
18 only see him twice under that code, and
19 that's -- you can ask the other doctors on
20 this panel -- that's an incredibly commonly
21 used code. It is not a long amount of
22 time. It's not a terribly high
23 reimbursement. And so that is something
24 that if we can talk about that limitation
25 being lifted, because, to be honest, 99211

1 isn't -- or 212 aren't even codes that
2 would be billed. I mean, they are -- 99211
3 doesn't even require a doctor's presence, I
4 don't think. And so that is something that
5 from a care perspective does kind of bind
6 us to be able to take care of patients
7 appropriately with longer-term issues.
8 MS. LEE: I would think that that sounds
9 like a great recommendation to look at
10 lifting those codes, and if you made that
11 recommendation maybe inserting what you
12 think may be appropriate. I think that
13 that is a good -- that would be a good
14 recommendation for the TAC to make, is for
15 us to talk about that limitation being
16 lifted.
17 DR. MUNSON: And that doesn't -- that code
18 does not affect just us. That's a --
19 that's a, you know, provider-wide code, so
20 it's not optometry specific. So I'm
21 actually kind of surprised that we would be
22 the first ones recommending that to the
23 MAC, but I feel that there would be
24 providers across the board that would
25 definitely be supportive of that change.

1 MS. LEE: And that would be one where we
2 would have to go back and we could look at
3 how many times that code has been billed
4 and more than once. I'm not sure -- the
5 only thing that we would have to go by
6 would be under the EPSDT, if it was ever
7 medically necessary, if it was ever under
8 the EPSDT benefit, if it was lifted. But
9 if you make that recommendation, I would
10 suggest you also include maybe some sort of
11 a recommended limit that you think would be
12 reasonable.

13 DR. MUNSON: Okay.

14 MS. LEE: That would help us determine
15 cost -- the cost of making that change.

16 DR. MUNSON: Okay.

17 MS. BEVINGTON: This is Dinah Bevington.
18 After we had the special meeting in
19 December we were asked to submit our
20 recommendations to the Department, which we
21 did December 29, 2022, and I'll send you a
22 copy of this correspondence that we
23 specifically requested that the limitation
24 be removed on those codes at that time. So
25 I'll send that to you so you've got a copy.

1 MS. LEE: And did that go to the MAC, too?
2 That went to the MAC and then --
3 MS. BEVINGTON: Yes, it also went to the
4 MAC as well.
5 MS. LEE: Okay. So we have it. I can look
6 it up, Dinah. There's no sense in sending
7 it to me. I can get it. And I'm assuming
8 that we responded to that?
9 MS. BEVINGTON: No, there was no response
10 to that specific -- that recommendation, it
11 looks like.
12 MS. LEE: Okay. I'll go back and take
13 that -- but if you have made that
14 recommendation, then I'll look -- I'll go
15 back and look at that and we'll take that
16 into consideration.
17 MS. BEVINGTON: Wonderful.
18 MS. LEE: Sorry for that oversight.
19 MS. BEVINGTON: That's all right. Thank
20 you very much.
21 DR. UPCHURCH: Most of your MCOs are paying
22 that code more than once because they
23 realize -- I've got one lady that has
24 recurrent iritis and I may see her ten or
25 12 times in a year. So most of the MCOs

1 are paying it more than once, but it's sort
2 of got their hands tied, too.

3 MS. LEE: And that is a good thing about
4 the MCOs, you know. They do have more
5 flexibility to provide some of those
6 services and exceed some of those
7 limitations. But that's good to know, too,
8 Dr. Upchurch. That gives us a little bit
9 more information that we can look in the
10 system about how many times that code has
11 been billed and paid with those limitations
12 lifted.

13 DR. MUNSON: Okay. Thank you for that.
14 And I apologize for presenting that kind of
15 backwards, but I appreciate you looking
16 into that for us.

17 And then I'm going to let Nicole from
18 Avesis -- I'm going to put you on the hot
19 seat. Avesis had some questions as well.

20 MS. ALLEN: Hello, Dr. Munson.

21 Actually, we presented -- we did
22 discuss the main one that we had questions
23 with, so thank you so much. We do
24 appreciate you bringing that forward.

25 DR. MUNSON: Oh, you're so welcome. Well,

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excellent. That is fantastic.

Okay. So is there any other general discussion from any members of the TAC committee today?

DR. COMPTON: Is this part of New Business? May I chime in?

DR. MUNSON: Yeah, we are ready for New Business.

DR. COMPTON: Okay. Earlier this week or late last week, I don't know, a colleague of mine called -- called billing and coding employee to let us know that the -- I can't think of the code right now off the top of my head.

MS. LEE: 66030?

DR. COMPTON: Yes, yes. And, Commissioner Lee, I thank you ahead of time for helping us. That that had been termed, I guess is a word from -- I don't know if it's Medicaid didn't pay anybody that, or just a term for -- that's fixed. But my bigger question is, is how does DMS decide what codes they will pay, what codes they will stop paying? Is there a process? Is it -- just to kind of avoid this issue again, or

1 at least have a heads up.

2 MS. LEE: We do have a process for the bulk
3 of our procedure codes. It's typically
4 based on Medicare. There are some things
5 that Medicare does not cover, but typically
6 our codes are -- we base our fee schedules
7 on Medicare, and our rates are developed on
8 a Kentucky-specific Medicare fee schedule.

9 With this particular code,
10 Dr. Compton, what happened is the Department
11 received some communication from an
12 association, and this is not uncommon. We
13 receive these sorts of communications all
14 the time. And we received a communication
15 that said that this code that we were
16 probably -- that we could be operating
17 outside of, or be in violation of KRS
18 320.210 specifically Section 2(b)3, which
19 relates to -- which relates to procedures
20 that were excluded from the scope of
21 practice of optometry. And the third one is
22 a nonlaser surgery, and it goes on to -- it
23 says requiring full thickness incision or
24 excision. So we interpreted that. What we
25 did is when we received that communication,

1 we went to the KRS and our interpretation
2 was, well, this code was not allowable. But
3 we have since had some communications, and
4 specifically we had some conversations with
5 Dinah, and she had pointed out that that was
6 not a correct interpretation, that the Board
7 of Optometric Associations actually -- in
8 2020 the Board of Examiners included that
9 code in the list of services, so we have
10 since reversed that code. We have put it
11 back on the fee schedule. We will be
12 reprocessing any claims that have come in.

13 So typically if it is -- you know, if
14 it's a change in scope or something like
15 that, we would definitely, you know, want to
16 reach out before we made a change. But
17 this, actually our interpretation led us to
18 believe that we were in violation of the
19 KRS, which was something that we would want
20 to change, you know, a lot sooner. And we
21 did do some research before we discontinued
22 this code on the fee schedule. We did do
23 some research and it showed that in the last
24 two years there were less than \$400 in
25 claims that were paid for that code. So

1 that, again, led to our interpretation as
2 this may not be, you know, a valid code for
3 the optometric fee schedule.

4 DR. COMPTON: Thank you for the
5 explanation. You have been a big help.

6 Probably the lower utilizations we are
7 dealing in our office, most of them are
8 Medicare, have commercial insurance. There
9 are very few Medicaid. It's generally an
10 older population that needs these
11 injections, so that may explain part of the
12 utilization. But you have been a huge help
13 on this entire meeting today and I really
14 appreciate it, so thank you.

15 DR. MUNSON: I definitely second that,
16 Dr. Compton.

17 So does anybody else have any general
18 discussion for today on the TAC committee?

19 Okay. So seeing none, Dr. Compton is
20 our MAC meeting representative. And so the
21 next MAC meeting is on May 25th, and he will
22 be in attendance for that.

23 I don't believe today that we have any
24 recommendations for him to take to that. If
25 anyone does, speak now or forever hold your

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peace. And if not, we will be having our next meeting on August 3rd at 1:00 p.m. I'm not sure if that will be Zoom or in person. That is above my pay grade. But that is something that we will discuss coming closer to that.

And so if there is no other discussion, then I will entertain a motion to adjourn.

DR. UPCHURCH: I'll make a motion.

DR. COMPTON: I'll second. I'm good at that today.

DR. MUNSON: All right. Thank you-all so much for being here. And, Commissioner Lee, I really appreciate you being on the call with us today. You have been incredibly helpful and we appreciated your support of all the patients in the Commonwealth of Kentucky.

MS. LEE: Thank you. And I appreciate everything you-all are doing for the Medicaid population.

DR. MUNSON: Thank you so much. Everyone have a great day.

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THEREUPON, the Optometric TAC Meeting was
concluded.

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