DEPARTMENT OF MEDICAID SERVICES
THERAPY SERVICES TECHNICAL ADVISORY COMMITTEE

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JANUARY 9, 2024
8:00 a.m.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Dale Lynn, Chair
Elise Kearns
Renea Sagaser
Emily Sacca
Kresta Wilson
Linda Derossett

MS. SHEETS: Dale, I will go ahead and turn it over to you.

MR. LYNN: Okay. Thank you. You said you we do have a quorum?

MS. SHEETS: I have you, I have Krista, Linda, and Renea. And I would like to remind the members in order to comply with Kentucky Open Meeting Laws, when you are voting you do need to have your camera on.

MR. LYNN: That's correct. Thank you.

Good morning, everyone. Thank you for being here this morning. The first thing on the agenda is to review the minutes from the November 14th meeting. I have already reviewed them and if the rest of the members would take a vote on accepting them or amending them.

MS. WILSON: I motion to approve, Dale.

MR. LYNN: Any "yays"?

MS. DERROSSETT: Yes.

MS. SAGESER: I also do.

MR. LYNN: Okay. Thank you. We

accept the minutes. I approve as well.

The first thing on old business is to follow up from the Department of Medicaid Services. What are the departments study findings on increasing the PT, OT, and speech fee schedule? This has been on the agenda for quite some time and we are just asking for a follow-up if anybody with DMS is on here to address that.

MS. SHEETS: I believe Justin Dearinger would be the one to address that and I don't see him on yet. So if you want to move on to the second item maybe we can circle back around.

MR. LYNN: Okay.

Thank you. The second thing on the old business is the follow-up with the process of getting a retro PA from traditional Medicaid when a member applies for disability and it is assigned from an MCO back to traditional Medicaid.

So is there anyone on here from DMS that could address this, how is that process going to make this smoother?

MS. KITCHEN: This is Kelly Kitchen.

For prior authorizations, any time that someone is in an MCO, and they are then assigned to traditional Medicaid, that provider has one year from the date that they were assigned as traditional Medicaid to get a prior authorization.

MR. LYNN: So is this process going any smoother to retro back and pick up the traditional Medicaid auth?

MS. SAGESER: Sorry, Dale. I think -- I was driving here and I had to pull over.

So I think that the issue is that it's just constantly -- we are still retroing back and so it is taking us -- it is just more work on our end and that we were asking if the state could take it so we aren't the middleman here. That is what we are asking.

Were you able to hear me?

MR. LYNN: Yes, I am. Thank you. In our clinic we have not had an issue with how to get a retro auth due to

this, so I can't address it from my clinic perspective, but I am hearing from other clinics that this is a lengthy process.

MS. SAGESER: It's the eligibility, yeah. The retro eligibility.

MR. LYNN: I understand that DMS is working on a process to make it smoother and faster to get these authorizations.

MS. ANDERSEN: Yes. This is Jennifer with APTwith Renea. I am the Revenue Cycle Director.

MR. LYNN: Hi, Jennifer.

MS. ANDERSEN: So two things on that. I believe on the last meeting, somebody from DMS said actually they would actually not require us to get the same auth if we already had one from the MCO. We could turn in the information from the other auth we had, and it would be approved, but expanding on that, the biggest issue isn't really the auth process, it is going back and even trying to get these claims paid all together.

We are not aware that these

retro changes even happen until an MCO recoups money from us. Oftentimes that is only leaving us a one- or two-month window to try to get these paid. In addition, a lot of the time, from what I am experiencing, we have had over $80,000 in retro eligibility recoupments happen over the last several months. So it is hitting us very hard to try to keep up with these, number one.

Number two, if I only have two months and a lot of these are already over one-year-old, and the special process that we have to go through has been very unclear of how to get these claims past that timely filing edit, because we are already past a year, I cannot just submit these like normal to get paid.

It is extremely burdensome and is just a process we cannot keep up with, and our window of time is extremely small by the time we are even made aware that this happened.

MR. LYNN: Yeah. That can be a serious problem as far as revenue,

especially with smaller practices. So what can DMS do to remedy this?

MS. KITCHEN: I think we need to take this back to Justin and see if there's anything that we can do to help assist the providers with this.

MS. ANDERSEN: I think Justin had said on the last meeting that they were looking at the possibility of just removing the providers from that financial process when these happen all together. They just, at that time, had not worked out what they would need to do to update the system and the process to make that happen, but I think, overall, that is what we would like to see happen, to see that financial exchange occur between the state and the MCOs and leave the providers out of it.

MS. DERROSSETT: That was my understanding also, that they would recognize the authorization that was already received and they would just go ahead and authorize.

MR. LYNN: So are they -- is DMS

paying retro back pay, these recruitments right away?

MS. ANDERSEN: Once we can obtain a auth, as long as the claim is less than a year old then yes, we can get that made. The troublesome part is when the claim is over a year old already. The problem is to go through on that is a lot more cumbersome and there is a lot more paperwork involved.

MR. LYNN: Well, hopefully whenever Justin gets on, he can give us some data on that and how we can make that process better. So when Justin gets on, we will go back to number one and two in old business.

The next thing on old business is the credentialing process. Assistant Director, Jeremy Armstrong, talked to Kresta Wilson, I think it was, last month, about the credentialing timeline and it is 30 days for the MCOs, and then ten days to upload the new therapist in the system for processing claims.

Is Jeremy on this call this

morning?

MR. ARMSTRONG: Good morning. This is Jeremy. Yes, I'm here.

MR. LYNN: Good morning, Jeremy. Could you address this?

MR. ARMSTRONG: Yes, sir, I did. We shared communications across all MCO plans, the expectation, plus we made a contract amendment that went into effect on 1/1/24 just to ensure alignment to regulation and expected turnaround times for these MCOs to credential, complete credentialing for a provider within 30 days, contract with the provider within 30 days, and then upload the providers fee schedules appropriately within ten days.

MS. WILSON: So that's 70 days possible from start to finish. That correct?

MR. ARMSTRONG: That is correct.

MS. WILSON: Just so there's not confusion there. It's a little confusing sometimes -- at least on my end. I was confused about 30, 60, 90. Everybody was saying something different. So if that

makes sense -- it is 30, 30, 10. It's an easy way to remember. Thank you for the clarification, Jeremy.

MR. LYNN: So 30 for the Medicaid, and then 30 for the MCO, and 10 to upload, right?

MR. ARMSTRONG: No. So credentialing still has 30 days with the MCOs and then contracting has 30 days. Both are 30 days to allow the MCOs and the providers to engage to ensure that the MCOs receive a clean application for credentialing. And then from the contracting perspective they have 30 days to have an executed signed agreement between the provider and the MCO claims, and once that signed agreement is in place, those MCOs have 10 days to load those provider-specific fee schedules and contracted rates into their system.

MR. LYNN: Got it. That makes sense now.

MS. MARSHALL: Dale, this is Pam. Can I ask a question?

MR. LYNN: Sure.

MS. MARSHALL: Hey, Jeremy, what is the process for noncompliance? Because I think all of us have experienced noncompliance even with the past understanding of 90 days, that this is now less time. I can't imagine that unless processes are changed by the MCOs, there are some that will not be able to meet this timeline under current conditions unless they change things. So my question is: What then do we do, what is the process to hold them accountable for that?

MR. ARMSTRONG: Well, one of the first steps that a provider should take when a policy, or a disagreement with the policy, or noncompliance issue to state contract and regulations, one of the first steps that a provider can take is filing that grievance through the MCO plan. The grievance will allow the MCOs an opportunity to correct or rectify with that provider directly. But then, for anything noncompliance, issues that still fall into that bucket, come into the state to report through the provider MCO inquiry

box, that noncompliance issues would be the expectation to follow up with the providers, for the state to take action of noncompliance against the managed-care organizations.

Now, I can put that email box in the chat so that way everyone would be able to have access to it. But the department, I can say, is continuously monitoring our MCO plans on their credentialing, contracting, and loading providers. So if you do receive something outside -- if the MCOs are not processing outside of the timelines that have been described today, please, be sure to bring those to the state's attention.

MR. LYNN: All right. Thank you, Jeremy.

The next item on old business is to request the following CPT codes to be added to the PT, speech OT, fee schedule and those were added to the fee schedule. They had been approved, and there was a question from a TAC member if they will be loaded into the 2024 fee schedule.

MS. KITCHEN: Yes. We have a request submitted and added in the system. You know that takes a little bit of time for them to get the system updated and we will be adding them to the fee schedule.

MR. LYNN: Thank you, Kelly.

MS. KITCHEN: You're welcome.

MS. MARSHALL: Dale, I have a question. It's Pam.

MR. LYNN: Okay.

MS. MARSHALL: One of the questions is: What is DMS's -- what is the client's expectations for the MCOs to get those codes added to the prior auth process, so each MCO has a different prior auth process and a different way to submit. Currently on our fee schedule, there are some CPT codes that are approved that are not able to be obtained through -- like, the codes are not even a choice for the PA, yet there is no medical policy stating otherwise from that MCO. So what is the DMS's compliance to hold the MCO accountable that all the codes on the fee schedule are available for prior

auth and use? In regards to these new codes and current codes.

MR. LYNN: Is there anyone from DMS that can answer that?

MR. ARMSTRONG: This is Jeremy. So when we update or add a new code to our fee schedules, we send a notification to all of our MCO plans, with the expectations that within 30 days, they will have those codes added to their fee schedules for the impacted providers, and then any of those codes that are expected to have that prior authorization utilization, should be added within those 30 days as well.

MS. MARSHALL: And then what is the step, Jeremy, if we are unable to obtain a prior auth for certain codes that are on the fee schedule? What is the process for getting that corrected?

MR. ARMSTRONG: So one of the first steps is to engage with those specific MCO plans. However, if you are getting any type of pushback or delays beyond that 30 days, that is when you can

come to the state -- to the department -- to bring an issue of that concern and we can rectify that. Because that would be the expectation for the MCOs to follow.

MR. LYNN: Does that answer your question, Pam?

MS. MARSHALL: It does. I'll go back and confirm. I'm fairly certain we have already dealt with the MCO but nothing's changed, but I will double check that before submitting that to you, Jeremy, that there's noncompliance in that area.

MR. ARMSTRONG: Thank you, Pam.

MR. LYNN: The next thing on old business is the Medicaid complaint process. I understand that has been changed somewhat, and it's a lot more lengthy process. Can anybody from DMS comment on that?

MR. ARMSTRONG: So this is Jeremy, again, with DMS. What has changed in the medical complaint process is the reviewing of the provider complaints that are received. In identifying what we have

identified within those provider complaints is a behavior of providers attempting to come to the state first to report the issues or concerns, and not specifically following the MCOs internal disputes and appeals process. And so that was a change from the medical complaint process, that if a Medicaid liaisons for the MCOs to receive and review a provider complaint indicate or see that the provider hasn't followed those internal dispute processes, then they are within their timeliness to take those actions and those are the responses back that the providers are receiving to follow that route first. And that is truly just to afford the MCOs the ability within their individual contracts that they have with providers, for the providers to be following those internal disputes and appeals process.

So that is really the change, as far as, we have updated a little bit of our form itself, which I'm happy to share with the therapy TAC attendees as well,

but really the change is just to identify the providers that have not followed the internal dispute appeal processes within those timelines, and if they are able to follow those internal dispute and appeal processes, then that is the department's request back to what has been submitted. So first to attempt is to try and go that route, and once the decision of determination has been received by the MCO plant then you can take those next additional steps for either an external independent third-party review, or potentially come into the state to file the provider complaint. Just understand that coming to the state first to file a provider complaint, it may not afford the provider the third-party extended review if you have not already taken that action within the 60 days of that adverse benefit determination from the MCO.

MR. LYNN: Yeah. That makes sense. So the MCO has 60 days to resolve the complaint? Is that what you are saying?

MR. ARMSTRONG: It's more or less the MCO appeal and disputes. The provider has 60 days to file a dispute or appeal and then you have, from that adverse benefit determination, you have an additional 60 days to file the EIR. And so I just don't want the providers who follow that first step of going through the appeal process, and then still not agreeing with the determination made by the MCO plans, and then come into the state where we don't have -- we won't necessarily be able to rectify all issues within 60 days, so then, essentially, if we don't have it resolved, then it essentially removes the provider's ability to file an EIR.

MR. LYNN: Yeah. That makes sense.

Well we had, at TheraTree, where I am employed, we had a complaint that we tried to work out with one of the MCOs and it never got resolved for six months, and so we filed a complaint with Medicaid and actually never heard back from them.

MR. ARMSTRONG: Dale, I would really like to see that example.

MR. LYNN: Okay.

MR. ARMSTRONG: If you had made outreach through submission of a provider complaint, whether it be via email through the provider MCO inquiry box, or through the mail, sending it through the state or to the department, or submitting it by fax, we had some issues with our fax line so if it was potentially submitted through the fax, it may have been missed. But, Dale, I would love to see at least in the example of how this submission was received --

MR. LYNN: Sure.

MR. ARMSTRONG: And if the issue still has not been addressed, then we can take actions to potentially address that concern.

MR. LYNN: I appreciate that. It was faxed, and it has probably been three months ago.

MR. ARMSTRONG: Okay.

MR. LYNN: I will email that

information directly to you. Okay?

MR. ARMSTRONG: Absolutely. And this goes for any of the TAC members on the call as well. If you all have submitted via fax, please, go ahead and outreach to the provider MCO inquiry box that was provided in the chat, because that is the team that facilitates provider complaints, and they will be able to assist and look into it further if it needs to be resubmitted, so that way we can take action.

MS. WILSON: Just a clarification on the 60 days, that applies to filing a complaint with the MCO in 60 days of the issue?

MR. ARMSTRONG: It's following the MCOs appeals and disputes process. So if you receive an adverse benefit determination that you don't agree with, providers have 60 days to submit the appeals for that to the MCOs.

MS. WILSON: Okay.

MR. ARMSTRONG: MCOs have 30 days to make a determination from that

submission.

MS. WILSON: Okay. Thank you.

MR. LYNN: Thank you, Jeremy.

The next thing on the old business is the Therapy TAC proposed to the Kentucky Advisory Council for Medical Assistance to prohibit medical managed-care organizations from applying multiple payment reductions, MPPRs, to occupational therapy, physical therapy and speech therapy medical claims. The DMS response, the department reached out to the MCOs and was informed that none of the MCOs are utilizing MPPR for therapy claims at this time. In addition, if the TAC has a specific example that demonstrates an MCO is applying a MPPR to medical claims, DMS will address the issue with that specific MCO.

I don't know of any claims that MCOs have applied MPPR. Has anyone else on the TAC? No? So it, apparently, this is pretty much resolved by DMS, that if an MCO does apply MPPR to OPT or speech claims, then we should report that to DMS.

MS. MARSHALL: Dale, this is Pam. I think this was in reference to the surprise moves by WellCare trying to apply MPPR without proper notification.

MR. LYNN: Yes. That's what it was.

MS. MARSHALL: Yes.

MR. LYNN: But they didn't do it, that I know of.

MS. MARSHALL: Correct. Correct.

MR. ARMSTRONG: This is Jeremy. Just to confirm that that expectation for the MCOs to not be utilizing that MPPR for reduction was a communication that I sent. So if there is anything that you all are seeing from the TAC members differently, please don't hesitate to bring that directly to my attention, so that way I can quickly get that addressed.

MR. LYNN: Okay. Thank you.

The next thing up is new business.

MS. WILSON: Dale, I think we need to go back to number one.

MR. LYNN: Oh, is Justin on here?

MR. DEARINGER: He is. I apologize.

MR. LYNN: Oh, okay. How you doing, Justin?

MR. DEARINGER: Good sir, how are you?

MR. LYNN: Good. The first question in old business was a follow-up from the department about their studies on increasing OT's, PT, and speech fee schedules. We just, kind of, wanted an update on that.

MR. DEARINGER: Yes, sir. So that study has not been fully completed yet. We are doing some things in the meantime to try to give some assistance. You all know that we update our fee schedules every year in accordance with the Medicaid rates -- I'm sorry the Medicare rates. And so sometimes the fees increase and sometimes they decrease and we make those changes accordingly.

This year, we have increased the

fees that have increased through the Medicare increased rates, and we have not decreased any of the rates. So we left that out this year. Anything that decreased, we left it the same that was on the 2023 fee schedule. So we were able to get that done for you guys.

We are also in multiple talks on several different key issues on exactly how we can work with rates and keeping those comparable. So we have a lot of different projects going on, other than just that main fee study, that could potentially see some rate changes in the future. The last thing that we are doing -- well not the last thing -- there are two separate projects that have started.

One is a prior authorization review. I wanted to let you know that we are working on that. We actually hired a new employee, and this is going to be their first assignment. Although we have started on it on our own, but their primary first assignment -- and this is

what their entire background is in, research and policy -- and so this is their first project will be reviewing prior authorizations for therapy. They will actually be starting with therapy and durable medical equipment. But they will be looking at every single prior authorization that we ask for from therapy providers and we are going to be going through that to see if we believe that is 100 percent necessary.

If it's not, then we are going to get rid of that prior authorization. In addition to that, and as a part of that, we are also reviewing the prior authorization process to try to make sure that that is easier for you all, as providers, and to make sure to see how it is submitted, and what information is required to get prior authorization and payment, and to reduce the lack of information that you all receive. The LOIs. We want to make sure that those are -- if there is information that is not 100 percent necessary, that you all have a

lot more time to get that in so you are not waiting on an LOI for something that is trivial. A lot of different projects in that area that we are working on.

And then the last thing that we have started is a project to review all of the different measurables for therapies. Part of that is looking at the fee schedule and looking at all of the different limitations on the fee schedule to make sure that those are still appropriate, and to see if there is relief that we can give providers as far as that area goes too.

So we are tackling this in several different ways while we are waiting on the fee schedule, study results, to, kind of, give you all some relief and kind of help you all out.

I want you to know that every single day we are working on something, some project with therapies in mind, and as you all as providers.

MR. LYNN: Thank you, Jeremy. Is there a projected date where the 2024

fee schedule will be published?

MR. DEARINGER: We are hoping to get that out as soon as we can. I don't have an exact date right now, but it should be done fairly soon.

MR. LYNN: Okay.

MS. SAGESER: Justin, with the rate studies, is there a projected date of when that is going to be completed? I know those can take several years. Are we heading down a two-year process here?

MR. DEARINGER: No. No. I think we will be getting that done sometime -- I don't have an exact date. I thought it would be done by now. I think they are looking at some time in the spring, like a March, April date. That's my thoughts, but I don't have an exact date. We haven't set that. They've ran into -- it's a complicated rate study, and so they've ran into issues, and we had to go back and readjust what we are looking at, and, you know, how it affected Kentucky, in particular. A lot of states do therapies a lot of different ways so

when we kind of collated all of that information, it didn't exactly line up so we had to go back and re-look at that. So that's the ballpark.

MS. SAGESER: I think the main concern is we are in this tight window, if it doesn't happen within this month, then it might not happen for another two years based on the state's budget.

MR. DEARINGER: Right. And then -- we weren't given any extra money in the budget for anything, so, you know, that's always something to think about. The rate study will dictate the rate change. I don't think it's something that is necessarily tied directly to this month. There's always ways that we can, you know, make the changes we need to make.

MS. WILSON: I have a question about the claims, since we don't have the fee schedule yet for 2024, will all of the claims for each MCO, do you know if that's -- if they're required to automatically reprocess those, or do we

have to manually resend claims to get them?

MR. DEARINGER: They will automatically reprocess claims.

MS. WILSON: For every single one?

MR. DEARINGER: Yes.

MS. WILSON: Okay. Sometimes we have issues with certain MCOs that --

MR. DEARINGER: Any issues again, please, let us know.

MS. WILSON: Thank you.

MS. MARSHALL: Dale, this is Pam. If I can talk, again, about that.

MR. LYNN: Okay.

MS. MARSHALL: So in past years, there are MCOs that refuse to retro reprocess, meaning they will only go from -- say, the fee schedule was approved March 1, and they have 45 days to load, they will only go, then, from whatever that date is -- April 15th if that's 45 days, they will only go forward from that date. So they will pay it all on last year's fee schedule until that date. So

that's why we need clarification, just so we know what the rules are.

MR. DEARINGER: Sure. And we can send something out if you would like for us to. I thought that was pretty well-established, but if you have that issue come up, we can definitely handle that. We have an effective date that's listed on that fee schedule, and those fee schedules are tied to contracts, so that shouldn't be an issue, Pam.

MS. MARSHALL: Okay great. So I'm understanding you saying if the effective date is 1/1/24, then that is what is expected.

MR. DEARINGER: That is correct. Of course, I'm talking about traditional fee-for-service Medicaid, and MCOs have to provide a minimum of what is on those fee schedules. Of course, each MCO will have its own contract with each provider, so some of that depends on what is exactly in that contract, too.

MR. LYNN: Justin, you were out for old business item number two,

following up on the process of getting the retro PA from traditional Medicaid when a member applies for disability and it's assigned from an MCO back to a traditional Medicaid.

MR. DEARINGER: Yes, sir. We've got that process -- we are working on getting it taken care of. It's kind of a complicated process, but we are working on that. If there's any, if you have those issues, if you bring those directly to us, we can get those handled quickly, until we get our systems completely aligned. But I want you to know that we are working on that system right now. It is just a system change that we are trying to get completed, but we are working on it, and in the meantime, if you have any of those, let us know.

MR. LYNN: Okay. Thank you, Justin.

I just noticed that I skipped over item number six on old business: The physician's signature on the plan of care. DMS prior authorization reviewers

continues to require signature on plan of care before processing PA requests, and that shouldn't be the case. Is there a way that DMS can communicate with the reviewers -- PA reviewers -- and get that information to them that the physician's signature is not required on that plan of care?

MR. DEARINGER: So I think we're going to have an individual from DMS reach out to you all and start having some more frequent meetings -- just, kind of, in between meetings to make sure that we, kind of, understand each scenario and situation. I think this is one of the situations where we had gotten a request for some relief on this issue, and previously the physician, I think it's 9073005, I think is the regulation that allows the electronic signature, but prior to that, the requirement was that the physician had to sign -- the same physician that ordered the therapy had to re-sign it in order for it to be valid. We opened that up after hearing back from

you all, and sent a letter out confirming that in August, that instead of having that same physician having to sign that, any physician could sign it, and it can also be signed by an APRN, a physician's assistant, and it could also be signed by a registered nurse that was in that same physician's group with approval from the physician. So it opens it up to where, you know, instead of having to have that same physician sign it, it could be signed by a myriad of clinicians that are working with that physician or that physician's area.

MS. MARSHALL: Dale, can I speak? This is Pam.

MR. LYNN: Sure.

MS. MARSHALL: So Jeremy, I just wanted a minute to talk about this, as I work with -- I am aware of people in other states who work with their state Medicaid on this exact issue. So one of the differences between CMS with Medicare rules is that there -- for everything, the language is around rehabilitation. And

rehabilitation is when someone lost the skills that they had. And in Medicare, frequently, therapy for rehabilitation is a fall, an accident, an injury, an event like a stroke, something happening, maybe surgery. So the medical follow-up by the physician, a lot of times these patients are coming out of hospitalization, they are post surgery, that's why the requirement for the signature on that plan of care is so important. But under the age of 18, when you are looking at Medicaid in the state of Kentucky, you are talking about, largely habilitation. The child has largely never acquired the skill. It is habilitative services. And what we are seeing in our area is many pediatricians, like, private groups of pediatricians, are no longer accepting Medicaid. In fact, there are hundreds and hundreds -- I don't even know how many -- lots of children who are going to be without primary care, as they are making these changes. And that puts a lot of stress on the few, mostly hospital groups

who are accepting Medicaid, or the outlying rural primary cares that are now going to have to absorb some of these patients.

Even though, the electronic signature is allowed, this is the process for a therapy group communicating with the pediatrician office. It is faxing, because our EMR systems don't communicate with theirs, so we have to fax the document, their office then has to print the document, then the doctor has to sign it, and then they have to scan it back. The problem isn't necessarily us getting it to them, we then have to babysit in trying to get it back. And you are talking hundreds, or even thousands of these things. The volume of therapy to a habilitative patient is much different. Medicaid is largely a short-term, it might be a 12-week-period, where habilitation can go on much longer -- 6-months or 12-months. Therefore, the frequency of these things coming at the physicians is much more frequent than a Medicare

physician signing. So you've got not only the difference in intensive medical patient versus the habilitated patient, but you've got the volume frequency. So I would recommend that our Therapy TAC ask DMS to discuss this with the Physician Therapy TAC, in particularly the pediatricians, and gather some information of their feedback. Because I think as a state, we can decide, do we think assigned plan of care is necessary, because us not getting them back from the physician means we have to stop that service, we h ave to interrupt that service, until we can do that. It's physically not possible for us to go to a physician office and stand there with, you know, 100 of these things to sign and get them to sign it and get that back.

(Audio issue.)

DR. THERIOT: This is Dr. Theriot and as a pediatrician, I just like to throw out --

MS. MARSHALL: Where it is signed. We have them signed --

MR. LYNN: I think Pam just went behind a mountain. She's traveling.

DR. THERIOT: I think, as a pediatrician, when the physician orders the therapy, they think that's it. They think the child is going to get it. They do not realize that the child is not going to get it until you sign that plan of care. So I see this as a real -- I did not even know that until I started in this job with Medicaid. They think they ordered it, they get this piece of paper that has the plan of care. They say oh, great they're getting it. There is no urgency in signing it. It would be a big lift to educate all of the providers that you have to sign this, and you have to keep signing them over and over, to make sure the child keeps getting the therapy. And the pediatricians don't know that because they are never going to change it. There is no reason for the pediatricians to sign it, basically giving your approval for that plan of care, because they don't know what the plan of care -- they don't

have the expertise to say no, don't do that, do this. They are never going to say it unless they happen to be a therapist, as well as a physician, so it's really a rubber stamp. It's never going to be changed. It just needs to be signed. So I do think that this is a big problem, and it's interfering with kids getting their services. So it is something that we need to look into. I just wanted to agree with you, Pam.

MS. MARSHALL: Thank you for that. Can you hear me now, Dale?

MR. LYNN: Yeah. You are not in a valley anymore.

MS. MARSHALL: Okay, great. I am driving through mountains. So I would like to propose that because the regulation -- the words in the regulation is, "in collaboration with." Currently, there is not anything for a provider, if they are going to read through every regulation, everything in writing, there is nothing that states a signed plan of care is required. Nothing. And

therefore, it's not required on the MCOs, not required in Medicaid. That's how it stands right now. So that's another point to this, that our practice, personally, has MCOs who are denying claims, telling us you do not have a signed plan of care, but it hasn't been a requirement. I mean, it's not written, so that needs to be cleared up, and then the decision of what do we do? What do we want in the state, because in my conversations with pediatricians, they agree with that same idea that you all are the experts. We think when we send this physician order over, that's saying that we want you to take over and help this child, meet the goals.

I believe that the medical necessity comes through the prior auth, meaning any reviewers, even if they are randomly reviewing documentation of the prior auth, that is the time to catch, is this medically necessary or not. It's not through an administrative process of a signature, because, you know, there's not

time in the day for that doctor to read all of those plans of cares. It just becomes a burden -- and an administrative burden, for sure.

MR. ARMSTRONG: Hey, Pam, this is Jeremy. The denials that you are seeing from the MCOs, is that across the board? Or is it specific to certain --

MS. MARSHALL: No. Yeah, it's certain MCOs and it's specific to reviewing our documentation, but us specifically being flagged on signed plan of care when, to our knowledge, that is not a requirement. In writing, it is not anywhere written.

MR. ARMSTRONG: Well, I am always happy to engage with our MCOs to clear the understanding and expectation of our interpretation of the regulation and so, Pam, if you want to send me an email, or any of the TAC members, send me an email that you are seeing this behavior differently, I will be happy to express that messaging to the MCO plans.

MS. MARSHALL: Okay, great.

MR. DEARINGER: Pam, I think it was a great idea that you had. I think this is something that we tried to address with the letter in August. Maybe it didn't have the intended effect that we thought it might, so we can definitely meet, and I think your suggestion of getting together with the Physicians TAC, having Dr. Theriot on, having some physicians on that are pediatricians, you know, hearing your concerns and allow them to listen to what you all have to say and then let them think about that and formulate a response. We want what's best for the members and their healthcare, so I think we can come to -- we can at least explore the possible change to this, and be open to that, for sure. Once we get that feedback, I think that's an amazing idea, so I will try to schedule that some time, hopefully we can get that scheduled this month, within the next couple of weeks, and then see where that meeting goes, and then revisit that on our meetings in between TAC meetings. Does

that sound like a good plan?

MR. LYNN: Does to me. Yes.

MS. DERROSSETT: I think so Justin. One other -- can I? I was going to make a comment, too. One thing too, even like CMS, they do require a signed plan of care, but they also have, what they call, a delayed certification, so they know there is going to be a delay a lot of times. For you to require it during the authorization process, when you can have a delay to get that, that's what is the hold up, too. Even if they say yes, you have to have a signed plan of care at one time or another, if you are allowing the delayed certification, that usually means you can go ahead and start therapy services, until you get that. So I would like for them to look at that, also.

MR. DEARINGER: Did the change in policy we made back in August, did that help at all? Or was that really of no help? Just curious.

MR. LYNN: I think what the

problem is, Justin, with traditional Medicaid, is when they tried to get that auth through the new portal, it's the same situation there, that they are requiring the signature. So we always do get the signature before we -- at our practice -- it makes it pretty hard for several practices to be able to do that, that are larger and who deal with physician's offices who are much larger and busier than ours.

MS. SACCA: Justin and Jeremy, I will add to what Pam is saying that we are seeing that in the adult populations as well. I, myself, had an experience with a wound care patient, where we had to delay care for up to a week because we were awaiting that denial, looking through peer-to-peer to identify and once we had a peer review conversation it was because we were missing that signed plan of care. Despite having the conversation that was not a requirement, had to close that and redo and resubmit an authorization. I would agree that a conversation between

the Physician TAC and the Therapy TAC on that administrative burden would be beneficial in the adult population as well as the pediatric population, because it really is delaying services that these providers are sending to us to provide, and using our expertise in the matters.

MS. ANDERSEN: This is Jennifer, APT. Can I add something on that?

MR. LYNN: Sure.

MS. ANDERSEN: We do have -- I have in email and a letter from Commissioner Lee that DMS has agreed not to require signatures for the authorization process. I have even been sending those letters, along with an authorization request to the auth portal team and they are still -- I don't think it's every worker there, but we will still get an LOI saying we don't care. Yes, I can see in writing, that this isn't supposed to be required, but I'm going to go ahead and request that signed POC anyway.

And I want to make something

very clear, because Linda touched on those delayed certs with CMS. CMS doesn't just allow for delayed certs. They allow for missing certs. They clearly outline, black and white, in CMS guidelines, that the purpose of requiring POCs or having a delayed or missing COE, the intent is to not have the patient to stop receiving services. That is not their intent. They make it very clear, the patient is still supposed to be allowed to continue receiving services even if a POC is missing or delayed. And they do make allowances on how you can remain in compliances when both of those situations happen.

But through the authorization process, we do not that ability at all. We only have a 30-day retro window, we are getting authorizations after we are already providing services trying to run on good faith that someday, somewhere this physician is going to sign this, and someone is going to approve this, and it is just not happening.

We are also being asked to change our plan of care dates to match the authorization start dates perfectly, and our authorization periods, particularly when 20 visits are free, don't match the POC dates, and we are being asked to revise those POCs and send them to the physicians which is doubling up on all of the POCs that they have to sign and they are getting very angry. When they come back and say, I just signed this two weeks ago.

MS. SACCA: We are experiencing the same thing. This is Pam Marshall. We are even, again, the MCOs are trying to hold accountable treatment plans missing established time frames with start/stop dates and visits even though, we think we have the right information on there. So I think this whole requirement of signed plan of cares and the date ranges need to be clarified through this committee, through the TAC, so that the MCOs have that information, and that it is not so difficult for the provider.

MS. ARMSTRONG: This is Hilary Armstrong with Foundation Hand and Physical Therapy Enrichment and we are dealing with these exact same issues, as well.

MR. LYNN: Well, hopefully, we can get this resolved soon. Justin?

MS. SAGER: This is Renea. I just want to remind everybody we've been talking about this for way over --

MR. LYNN: Years.

MS. SAGER: -- six or seven months. Yes, years. At what point are we going to get --

MR. DEARINGER: We have been and, again, you know, we went through the big change in August, and I thought that would be -- that would kind of do the trick, and obviously it has not, so I think this next step is to make another change, obviously.

We will get -- I know it has kind of been ongoing, but we will get some resolution to it quickly. I will try to get a meeting set up within a couple weeks

and we will take a -- we will have a resolution from that meeting one way or the other. It sounds like there's a lot of little issues too, inbetween there, but let's see if we can just attack the big issue first, and then we might not have to worry about any of those little ones.

MR. LYNN: All right. Thank you Justin.

Let's be ready to move on to new business. The first item on new business is to request to add the speech therapy to the speech therapy fee schedule, CPT Code 92605, evaluation for prescription of nonspeech generating augmentative and alternative communication device, face-to-face with the patient for the first hour.

MR. DEARINGER: We will research that and see if we can add that.

MR. LYNN: All right. Thank you.

The next item on new business is provider reports when requesting a speech prior authorization through the DMS

portal. They are asking for proof that the patient is not receiving duplicate services at school.

Pam, if you are still on, can you address this? I know this has happened to you.

MS. MARSHALL: Yes. I am still on.

So we've had -- we've had this with -- I can't quote right now who, but we have experienced this requirement where they are sending back proof that there's no duplication of service at school. Typically, we are medical model outpatient, and we don't get the school information -- we don't have the IEP. Many times the parents have not signed a release for us sometimes to even get that. Normally, we have to have that release signed before we can come to the school or before the school will talk to us. So its holding up the prior auth -- they are saying they need it, and it is required. And we are saying that because of FERPA, we don't have access to that information.

And they really are two different services -- educational versus medical model.

So I'm just wondering if we can have a discussion about this issue and what's needed -- does the parent need to submit that? I don't understand what would be a good solution, but we can't be the middle person trying to obtain an IEP, meanwhile services are delayed waiting on the PA to prove that there is not duplication of service.

MR. DEARINGER: So pam, this is the first time that I've ever heard of this, and we are checking in with our systems people to see what's going on with that. That's not something --

MS. MARSHALL: Does anyone else on the call have that?

MS. ANDERSEN: Yes. ATP over the last, I want to say, two weeks, just started getting an influx of those requests as well and it just kind of started out of the blue. Same issue, we don't necessarily know, and if we are

aware that they are getting services at the school, like Pam said, we don't have those IEP's. Our therapists may make an effort to collaborate and find that information out, but my auth team does not know that, and it just really is not going to provide this information.

MS. MARSHALL: Yes. And it's also my understanding that the school IEP's, they no longer have separate therapy goals. Like, there isn't standalone speech goals or standalone OT or standalone PT. And we are getting that request for OT and PT, as well. So that is the other confusing part is I can't imagine that we would have the same goals or we shouldn't, because I don't think -- if we had similar goals to school, it would not meet medical necessity requirements. It would not meet inner qual guidelines for Medicaid for any Medicaid service. So it's a little confusing why this is a thing, or why this is even being brought up. I understand that it is in the ray that we can't

duplicate service, but I don't think it's our responsibility to prove that we are not.

MS. JONES: Pam, this is Erica Jones. Thank you for bringing this to our attention.

So a school is required to provide those services that are in the IEP regardless of whether or not they are reimbursed by Medicaid. So those authorizations should be two separate processes -- the ones for the school and the ones outside in the community setting. So if you would allow us some time to look into what's been happening, I guess, the last few weeks, for why they are requiring proof, and then I will see if CMS can provide us some different models to make sure that this doesn't happen.

MS. MARSHALL: Okay. That would be great. It made my mind wonder, down the road, that if this was a requirement, then how would you decide, if it was decided that you submit an IEP and someone decided that this is duplication of

service, how do you determine who gets paid? That was the other thing I thought of. Like, oh no, would outpatient get paid or would school get paid? Who would get paid if they are billing Medicaid?

MR. LYNN: So I have a question. Erica, the new reviewers with this new portal, are they all within the state of Kentucky? Because I am wondering if possibly, they may live in a state where that is a requirement, and they just misunderstand the laws of Kentucky about this.

MR. DEARINGER: Yeah. I'm not sure about that, to be honest, because they are not state employees, they are contracted. So that is a good question. I know there has been a couple prior authorization issues that have come up that are training-related. I don't know if this is one of them or not. This is one that we will have to check into and do some digging to see. I agree it is not the providers, you know, job to prove that it is not duplication of services, so let

us dig into it a little bit and see what we can find out.

MR. LYNN: And like Pam said, the IEPs are written so differently, the plan of care for OT, PT, and speech and then medical model. The goals are blended into the teacher's goals on the IEP. So it would be really hard to tease out whether we are duplicating services anyway. So it would be great if you guys could look into that and get some resolution on that.

DR. THERIOT: Hi. This is Dr. Theriot again. I think it would be fine to assume that it is not a duplication of services, because the educational model versus the medical model is so different, and many times children are getting IEP services, which might be once a week, therapy in a group, and that's what they get for their physical therapy, or speech therapy. And they obviously need more for medical reasons and so, once again, pediatricians will often say you need -- I know you are

getting this in the school, but we are going to refer you to therapy because you need so much more, and the school is going to -- you are going to meet those needs at the school and it's not even going to get near what you need for medical reasons. And I think people get mixed up when they hear that they are getting it at the school, but I do strongly feel that it is completely different, and it is not a duplication, and if it can just be two separate approval things, I think that would be great. Just my opinion.

MR. LYNN: At our practice, we actually have a checklist that we can give parents, like, for occupational therapy, for example, this would justify the occupational therapy in the school. This would justify occupational therapy in the outpatient setting. Because sometimes parents are confused of why am I getting OT at school and at this clinic? So this kind of explains the difference between the two models.

Okay. I guess we can move on to

the -- anybody -- I think, Linda, you had a concern about getting PAs that you mentioned to me in an earlier email. Do want to address that?

MS. DERROSSETT: Yes. I have talked to providers outside of our facility, as well, also, and they were saying that -- I think it was with traditional Medicaid, I said after the initial 20 visits, they were having to get reauthorizations and when they went to get them reauthorizations they were having to do it every 30 days, and sometimes it was taking up to two weeks to get the authorizations back, so by that time it was time for resubmitting again, and I didn't know if anybody could look into that process to see if we could speed it along, because we are either having to delay -- it's not because we don't have it back, or we are just having to continually redo it and redo it. It's just a very quick process and you are not even done with the 30 days before you're having to redo it again.

MS. ARMSTRONG: This is Hilary Armstrong, again, with Foundation Hand and Physical Therapy, and we are dealing with that same issue, as well, that we can't see the patient until we get that authorization back and, by then, two weeks have gone by and interrupted care as well.

MR. DEARINGER: Yeah. Thank you for bringing that to our attention. We will look into it and see what we can do. And that's after the 20 visits are up, right?

MS. DERROSSETT: Correct.

MR. LYNN: Okay. Any other issues from TAC members or public that they'd like to address?

If not, it doesn't look like we have any recommendations for the MAC. Is that correct, the rest of the TAC members?

MR. WILSON: I think we have enough to keep Justin busy for awhile.

MR. LYNN: Justin and Jeremy, both.

MR. WILSON: Yeah. And Jeremy, too.

MR. LYNN: We appreciate you guys.

MR. WILSON: I hope you don't have anything else to do besides take care of us.

MR. DEARINGER: No. It's good, and I really enjoy the fact that we've started to have these meetings in between TAC meetings too, because I think -- and the meetings that we are going to have with the physicians, these are going to be great changes, I think, that we are looking at. So I think this has been very positive.

MR. LYNN: I agree.

MR. WILSON: Thank you very much.

MS. DERROSSETT: Yes. We appreciate your time. I said, is there anything that you are going to be working on, you, Justin or Jeremy, that needs to go to the MAC, or is it something that you can just handle?

MR. DEARINGER: No. I think at this point, we need to kind of see where

we are with these issues. I think the meetings with the physicians will have a resolution on that one from that. And I think, having us looking at the new issue of trying to prove duplication services in school settings, I think that is going to be something easy for us to look into and handle and then the PAs for after 20 visits, every 30 days, and its taking two weeks to get them, I think that we can look into that pretty easily.

So I don't see anything -- of course, adding codes to the fee schedules, that is commonplace, so I don't see anything right now on our end.

MR. LYNN: Okay. Thank you. And I'm available anytime, Jeremy or Justin, if you need to meet with me.

Okay, our next Therapy TAC meeting is Tuesday, March 12th, and I'd like to take a vote to adjourn this meeting.

MS. SACCA: So moved, Dale.

MR. LYNN: Okay. We will see you in March. Thank you.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 16th day of January, 2024

_____/s/ Stefanie Sweet__

Stefanie Sweet, CVR, RCP-M