CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
THERAPY
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
July 11, 2023
Commencing at 8:30 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dale Lynn, Chair

Linda Derossett

Kresta Wilson

Emily Sacca

Renea Sageser

P R O C E E D I N G S

MS. SHEETS: Good morning, everyone. This is Kelli Sheets with DMS.

I believe it is 8:30, and we do have a quorum, I believe. I have Dale, Kresta, and Linda on. Am I missing anyone?

(No response.)

MS. SHEETS: Okay. That does make a quorum. I'd just like to remind everyone, for the members, if you will be voting, you need to have your camera on in order to meet open records -- open meetings laws. So with that, I'll turn it over to you, Dale.

CHAIRMAN LYNN: Thank you, Kelli. Good morning, everyone, and welcome to the Kentucky Medicaid Therapy TAC meeting. The first thing on the agenda is to review and approve the May 12th minutes. Has everybody had a chance to read those and...

MS. WILSON: Everything looks good, Dale.

CHAIRMAN LYNN: Do you want to make a motion to --

MS. WILSON: Yes, sir. I'll make a motion to approve.

CHAIRMAN LYNN: Good. Linda, I guess we need to vote on that. Good morning, Emily.

MS. SACCA: Good morning, everyone.

CHAIRMAN LYNN: There's not a lot of business on the agenda today, but what's the old business. The first item on the agenda is a follow-up from the Department of Medicaid Services.

What are the Department's study findings on increasing the OT, PT, and speech fee -- fee schedule? Just wondering how the progress is on that. Anyone from Kentucky Medicaid like to speak to that?

MS. SHEETS: I don't believe anyone from Medicaid is on that could speak to that. I can certainly take that back and ask for a follow-up.

CHAIRMAN LYNN: No. That's good. I was under the understanding they were going to try to have that study completed by mid-July. Just wondered what the progress is on it.

MS. TOLL: I'm currently on here. This is Cynthia Toll. I will need to take

that back to Justin and find out from him exactly where we stand on that because I'm not for sure.

CHAIRMAN LYNN: Okay. Thank you, Cynthia.

MS. WILSON: Can we have an update on that before our next TAC meeting?

MS. TOLL: Sure.

MS. WILSON: Okay. Thank you.

MS. TOLL: I will do my best. Let me just say that.

MS. WILSON: Sure. We just kind of want to know, like, where it stands because I know you all had to submit all of the information to the governor and whatnot so...

MR. SCOTT: This is Jonathan. I believe that we have submitted that. That may have been a different report that we submitted, but I think that that is going through the process and should be -- should be submitted to the LRC in the next couple of days if it's not already there. But I don't know that we have a version we can share with you today.

CHAIRMAN LYNN: Great, Jonathan.

Thank you.

The second old business on the agenda is a follow-up on traditional Medicaid requiring physician signatures on the plan of care. I think Justin was going to respond to that sometime in the last two months, but I haven't heard from him about what Medicaid's interpretation of "in collaboration with," and he --

MS. SHEETS: Hi. This is Kelli again. Justin is entering the meeting right now. I just admitted him. So --

CHAIRMAN LYNN: Great.

MS. SHEETS: -- as soon as he gets connected, he may be able to address that.

Justin, we're on No. 2 of the agenda, and they have asked if you could address that.

MR. DEARINGER: Absolutely. My -- so this is Justin Dearinger, acting director of the Division of Healthcare Policy.

Yes. That one is complete. We have -- we're finalizing the provider letter for this, so we will be sending that out hopefully this week. If not this week, next

week. In the meantime, we sent out a provider letter. It has to go through some processes. But you all will be receiving a provider letter that goes over this either this week or next week so...

But we have came out with an opinion based on our interpretation of the administrative regulation, the way we created it to read, for this. And it will be -- I think allow for a standard of -- for everyone to be able to use it the same way.

CHAIRMAN LYNN: Okay. So we look forward to seeing that letter, and hopefully this will ease the burden of getting prior authorizations with Kentucky Medicaid. It's quite a burden to have to get a physician's signature before we submit it to a PA. Often, we have to actually take the plan of care to a physician's office to get a signature.

MR. DEARINGER: I think it will definitely ease some burden so...

CHAIRMAN LYNN: Good. Glad to hear it.

MS. WILSON: Justin, since you gave

us an update before, are you -- any chance have an update on the -- submitting the fee schedule information?

MR. DEARINGER: Yeah. Well, no. Only that it's still in process. So as y'all know, we enlisted the assistance of a couple of contract agencies. They've still not completed their assessments yet. So we're still waiting on them to get back with their finalized reports before we can assess their data and make a determination.

MS. WILSON: I was under the impression that it had to be in the governor's office in July.

MR. DEARINGER: So that -- the report that was sent to the governor's office is a -- it doesn't accomplish the goals of what we're trying to accomplish. It accomplishes the goals of what the legislation asked for but not specifically what we're trying to do with -- which is look at every single CPT code for every single therapy type, provider, service from all different providers.

So, you know, we have school-based

prices. We have waiver prices. We have EPSDT prices. We have regular, you know, provider's pricing and then -- and then we have places like PPECs and other places that provide therapy, too, that give even different rates.

So all those things are being looked at, analyzed, evaluated, compared to other states on what their CPT code pricing is compared to Medicare. So it's an in-depth process that -- that they did not have time to -- to complete by that -- that process, they didn't have time to complete.

Now, they completed what was required of them by the statute, by the bill, and have sent that to the secretary's office for review and then sent that in. But that doesn't really have much bearing on this particular project that you all are talking about, the one that's going to determine what we do with rates specifically.

MS. WILSON: Okay. Thank you.

MR. DEARINGER: You're welcome.

MS. WILSON: Dale, can you let Renea in? I think she's trying to get in.

MS. SHEETS: Yeah. She's not in the waiting room. I got that email. She is not showing in the waiting room. I'm going to respond to her and ask her to maybe go out and try again.

MS. WILSON: Thanks.

MS. SHEETS: Sure.

MS. SACCA: Justin, this is Emily. I'm assuming that within that project, we are also reviewing "sometime therapy" CPT codes in relation to the wound care codes. There are several providers in our state that provide Medicare -- Medicaid services for wound care, so I wanted to make sure that those rates were being addressed as well.

MR. DEARINGER: We did. We do have those rates, anything that is billable by our providers and anything that's billable by other states' providers. That's part of what we're looking at, too, is: Do we have everything we need on our fee schedules?

MS. SACCA: Okay. I appreciate that. That's a niche that sometimes gets overlooked, so thank you for including that.

MR. DEARINGER: Sure.

CHAIRMAN LYNN: Okay. Thank you.

We can move on to the third item of old business. It's a follow-up with referencing the regulation the department used as a guideline when they permitted Evercor to create their own medical necessity criteria. I got a response, I think, from Jeremy Jones -- or we did, the TAC did, after the last meeting, but it wasn't relevant to that.

You know, whatever -- you know, whatever the regulation is. Is there some exact wordage in the regulation that would allow the Department to let Evercor create their own guidelines?

MR. DEARINGER: I don't have an answer for this one today. I'll have to see where we're at with that one and get back with you. I'm not sure. I wasn't -- I wasn't working on that one so -- somebody -- some other people were, so I'll have to check in with them and see where we're at with that and get back with you.

CHAIRMAN LYNN: I'd appreciate it. If you can try to let us know within the next couple of weeks --

MR. DEARINGER: Yes. Absolutely.

CHAIRMAN LYNN: -- with email, I'd appreciate it, Justin.

MR. DEARINGER: Yeah. Sure. The No. 1 agenda item, I don't have a time frame for it. No. 2 will be within the next two weeks for sure, you'll have that. And then I'll get an answer for No. 3 in the next two weeks, also.

And since we're talking about it, No. 4 is going to be on that same letter that goes out to you all. The answer for the guideline from us for that will be on that same exact letter, so it'll be a two-part letter.

CHAIRMAN LYNN: Yeah. That's great. It's -- the MCOs have a, you know, different criteria for getting prior authorizations than Medicaid does. And so when you have to try to get it retro whenever a member jumps over back to traditional Medicaid from an MCO, it's tough to get that authorization.

MR. DEARINGER: Yes, sir.

CHAIRMAN LYNN: I appreciate it.

MR. DEARINGER: Not a problem.

CHAIRMAN LYNN: On to new business, the TAC just has a question regarding the new authorization portal. Has there been, like, beta testing done for that portal or -- before it goes live?

MR. DEARINGER: Is there anybody else from Medicaid that would like to speak on that? Probably not. So they're having a team meeting currently, as we have this TAC, going over some of these -- some of this testing of the portal.

And so there's multiple phases of that. I'm not sure exactly where they are in their trial period or if they're going to do any kind of testing for providers before it actually goes live. So I don't -- I don't know for sure. I'd have to find out if they're going to do that or not.

MS. MARSHALL: Hey, Dale. This is Pam Marshall. Can we request from the Therapy TAC that there be some kind of trial, especially for our type of prior authorizations since we're a little bit different than some medical practices? Meaning a lot of times, some providers are

just getting, like, a one-time PA for a one-time event. And our PAs impact the child weekly, you know. And it would cause us to have to put children on hold and disrupt their services. So we just want to make sure that's not going to happen, that it -- all things work smoothly.

And, you know, I was around during the expansion of Medicaid in 2014. And the whole process back then didn't work to even get a PA, see a patient, get paid. Like, there were so many things wrong with the setup that I think it would maybe just prevent some problems if we could beta test it or make sure, you know, all the therapy types, it works before it goes live.

MR. DEARINGER: So that's a great suggestion. I'll definitely take that back and see. You know, any time there's a new program, there's an amount that's budgeted, a budget that's allocated to that. And so the software developers will -- you know, any amount of time that's spent in development is a time allotted in the budget.

So we have to make sure that we have

enough funding to do that and time to do that and all those kind of things. But let me see what I can find out and get back with you.

MS. MARSHALL: Well, and the other suggestion is, is there not a way to set up, you know, mock or fake patients and just let us try it with Medicaid employees versus the software employees? I don't know how all that works but...

MR. DEARINGER: Right. Yeah. And I think that's kind of, you know, one of the tools that they use when they're designing things. I mean, they'll have our employees go through it with, you know, Jane Doe, John Doe type patients. But then they will -- you know, sometimes they'll open that up to providers to do as well. Again, I have to see how this contract was set up and written and how much money and time is left in it.

MS. MARSHALL: Okay. Because I guess we would love to join the Medicaid employees if they are doing that sort of thing because sometimes having the eyes of people who actually provide the service, we can spot the problems, if there are any.

MR. DEARINGER: Absolutely. Let me -- let me see what I can find out. But I -- yeah, I understand.

CHAIRMAN LYNN: Thank you, Justin. Were there any other issues from TAC members or the public that's on this call?

MS. WILSON: Yeah. I have a question, I guess, for someone from Medicaid. I don't -- poor Justin. You're in the hot seat today. So I don't know if you can help or somebody else can.

But it's about the tracking of no-show visits. So you'll have a portal where we go on and put the information in. So I'm just curious, like, how you all are using that data. We had discussed it a little bit before, but it was -- I guess they're fairly new, or there wasn't a lot of information. People weren't really putting a lot on there.

So I don't know if that had improved, if there is more -- people are putting more information on there now. But each entry takes several minutes, you know, so we -- we kind of figured it up, just did, like, a random week. And it's taking our

administrative task -- administrative staff about an hour and a half or so, you know, to enter that stuff in every week. And we have, you know, some things in place, and we don't let those carry on and carry on.

But when you have a pretty decent-size Medicaid population, obviously that, you know, impacts your practice a whole lot. We have no recourse. Obviously, we can't charge them anything.

So I guess our question is, like: What's being done with the data? What's the plan for -- you know, is there going to be any kind of, you know -- what's the word I'm trying to say? Are the families going to have any consequences, I guess, for, you know, those no-shows and those visits that we just have nothing, get nothing? So do you have any updates or anything on that?

MR. DEARINGER: Yeah. So one of the -- the No. 1 issue we talk to providers -- especially when we have issues of areas where we don't have access, where we don't have enough providers in the area to provide the care that's needed for the

communities, the No. 1 issue is no-shows. And so in order to combat that, that no-show portal is really our main source of information. It's the main source of how we determine where we put our money, where we put our energy, where we put our efforts.

And, you know, it's not being utilized, and I understand it may be time-consuming. And maybe we can find a way to cut down on the amount of time it takes to enter information into that portal.

There's also a dashboard that's being created. It should have already been created, but it's being created to show no-show data. So it'll be a website. You'll be able to go on a website. You'll be able to see by provider type, by county no-shows, reason for the no-shows, things like that. And hopefully that will help increase providers using the no-show portal.

In addition, we're reimbursing for community health workers that may be beneficial in contacting individuals that don't show up and finding out reasons why they're not showing up and helping them

coordinate transportation or other things that they may need for appointments.

But our goal with that portal and what we do with it currently and what we're hoping to do with it when more providers become invested and start using it is to see what reasons individuals have for not showing up. What are the no-show reasons?

And I understand there's going to be a percentage, maybe a large percentage of individuals that because there are no consequences, they just don't show up. And there's nothing that we as the Department For Medicaid Services can do about that currently. That's a decision that has to come from the legislature or the governor's office.

But what we can do about that is all the other reasons; right? If there's a transportation issue, if there's an issue of them not understanding when the appointment is or how to call and reschedule the appointment. If there are other issues that are causing them to have no-shows, we can attack and address those issues and shrink

that percentage down to where it's a manageable number for providers and it's not the No. 1 reason providers aren't enrolling in Medicaid services.

MS. WILSON: Yeah. I think there's a lot of -- there's a variety of reasons. But I think all those issues you mentioned -- I mean, transportation -- all kinds of things come up. But at the end of the day, you know, are they going to be super motivated to get there because what difference does it make, you know.

As far as they're concerned, there's not, like, a monetary, you know, unless -- I mean, you've got families that are, you know, very committed. And, you know, they care about getting their kids there and that kind of thing. But it's just easier to say, oh, yeah, we'll just, you know, miss this one, whatever, you know. Or they'll forget to -- they won't call at all, obviously.

But, you know, that's -- there's lots of things that we try to point them -- resources and things that we try to point them in the direction of, too. And I know that you all

do provide -- certain Medicaid plans are offering transportation services and things like that. So we share all that information with our families, too.

So, you know, most of the time, it seems like it's questionable reasoning why they haven't shown up so -- which, like you said, I don't know that there's a whole lot that you can -- you know, your all's -- you can do, but maybe the governor or somebody else can do something with that but -- okay. Well, I'm glad to know that it's being looked at so...

MS. SHEETS: Justin, there's a question in the chat. Does an attendance policy for the facility go against any Medicaid regs?

MR. DEARINGER: As long as an attendance policy doesn't involve billing a patient, traditional fee-for-service Medicaid does not have any other requirements or limitations. That's my answer.

CHAIRMAN LYNN: That sounds reasonable.

MR. DEARINGER: That's

fee-for-service Medicaid, so any contract with the MCOs may be different.

CHAIRMAN LYNN: Would any of the MCOs like to speak to that as well?

MR. OWEN: This is Stuart Owen with WellCare. Yeah. You know, the problem is that federal Medicaid rules prohibit, prohibit. Like Kresta was saying, the reality is there are no consequences. There's nothing we can do.

There is -- you know, this wouldn't tell you why. There's an ICD-10 diagnosis code, which would be easier to report, you know, on a claim. That wouldn't be as time-consuming probably, and it's for patient left without being seen. Of course, we're talking about a no-show, but that would be easier for tracking but then that's not going to get you to the reason.

But, you know, I mean, I really think the reality is just like what Kresta said. Like, something came up. They just don't think about it, and there's no consequences. Or they just -- you know, I mean, we've heard that and heard that, you know, of patients

just canceling and, you know, getting text reminders day prior, morning of, and then not showing up.

And honestly, you know, there's telehealth now. They have transportation that's available. I really don't think it's that. But, you know, it just comes down to federal rules prohibit any kind of consequences, and I understand. I mean, you don't want to charge a fee, you know, to the Medicaid member for something like that.

I mean, but there is that ICD-10 code that could be a possibility for just tracking it, you know, easier. But it wouldn't say why because, you know, most of the time, they don't give a reason anyway. But it would be easier to put that on a claim.

MS. DEROSSETT: Could you use that, though, if they were never in the facility? Because it says left without being --

MR. OWEN: Right. Yeah. I mean, yeah. It's technically that they were there and left. That's the only thing. There is nothing for no-show, and there's no CPT code. Because, you know, it would be nice if

there's a CPT code even if it didn't pay anything just to track it, but there is none.

But yeah, I mean, you're right, Linda. They -- technically, it's if they left, and I don't know how often that happens. Probably not very often.

MS. WILSON: Usually only if they vomit.

MR. OWEN: Vomited and left.

MS. WILSON: That's when we make them leave.

MS. DEROSSETT: Now, this portal that you were talking about, we actually have not been using that portal. But -- so that tracks actual no-shows where they just don't come, but it also will track the -- put the cancellations in there if they actually called and gave a reason; correct?

MR. OWEN: Are you talking about DMS' portal? Yeah. Providers manually enter, like, when they get a no-show and why -- if the member even told them why, you know, the reason why.

MS. DEROSSETT: Because what is -- what's really sad is, like, some of these

kids that we're seeing, you know, that are the chronic no-shows, then you'll call and tell them, you know, you may have to discharge them. Then, all of a sudden, they'll show up that one time. Then they'll go three more weeks.

And what the very sad situation is, is these kids need it, I said, and, you know, the parents aren't bringing them for various reasons. So that's what's sad. You hate to discharge them because, you know, they really need it. But you can't keep them on the schedule and take up spaces for those kids that will come, also, so it's just a sad situation.

MR. OWEN: Yeah. And, you know, the ones that are hurt even -- as far as providers, even worse are the nonemergency medical transportation because they go. They actually drive to members' houses, and they are like, I'm not going today. So they've actually -- you know, gas, money, or whatever. I mean, I know that happens as well, that, you know, they make the appointment, and they show up. I'm not

going.

MS. SAGESER: Yeah. We track all of our no-show reasons, but we don't have time to put them on the portal. I mean, last week, we had 167 no-shows out of -- I don't know -- (audio glitch) -- to man that. And we just -- so our data, I was looking at just no-show reasons. I mean, it's crazy but, I mean, there's a lot. So we don't use the portal, Justin, so -- I don't know how we would have time.

And an example of that is, I mean, I'm fighting right now with Humana Medicaid, which is an issue I was going to bring up with Dale on the next point when we're ready to move forward. But this is an example of why I'm not able to put in no-shows or track some of those other things.

With Humana Medicaid, they said that we had a provider -- some providers that weren't showing as registered, and they took over 1,000 claims back from APT. Now, when we called, they said, oh, this is probably an error, which it was, but they took back 1,000 claims. Now we have to wait another 90 days

to get paid that again. Nothing -- no problem on our end. They said this is happening to multiple providers, so I wanted to see if this happened to anybody else.

But that's an issue of what we're fighting, Justin, of consistently working with different MCOs that are pulling back money and claims and then they're like, oh, this is an error on our part. I'm sorry. We will fix it. It's just going to take 90 days to fix it.

MS. HARRISON: Hi. This is Samantha Harrison with Humana. I haven't heard anything regarding this. We would be happy to work with you on that if you can contact us to address that situation. It may have been through a financial recovery related to encounters that were rejected, but let us look into that for you and see how we can move that forward.

MS. SAGESER: Yeah. We actually made a complaint with DMS, too, two weeks ago and have not -- Justin, haven't heard any response on that regarding who we've been in contact with.

So, Samantha, I can -- I'll find out who we've been working with on this and let you know here in just a few minutes.

MS. HARRISON: That would -- I appreciate that. I'll put our compliance email box in the chat, and you can reach out that way. Does that work?

MS. SAGESER: Yeah. The person we talked to said this was happening to multiple providers from Medicaid -- from Humana Medicaid. So it is just -- I'm just saying this is an example of administration burden, which is causing us a lot of headache and manpower. And, therefore, we're not able to track other things like the no-shows, and I just want to make sure that it's noted.

CHAIRMAN LYNN: Yeah. Renea, it's happened at our practice, also.

MS. SAGESER: Okay.

CHAIRMAN LYNN: With take-backs from Humana that -- actually, they hadn't taken anything back, but they said they were. And it was totally unjustified. And when we communicated with them, they said, yeah, that is a mistake so -- but it just took a while

for us to get it resolved.

MS. MARSHALL: Renea, it's Pam. I think we've had a few as well, but we were on it pretty quickly and resolved it. But yeah, I think we've had --

MS. SAGESER: Yeah. We were on it pretty quickly, too. The issue was we had a -- like, 1,000 claims because we have such a large provider network. And so because of that, now they're like, oh, it's another 90 days. It might be 60 days now. I don't know. That's just the frustrating piece.

So we did make a claim to the Department of Medicaid regarding that, but we haven't heard back anything, Justin. So I was wanting to talk about the timeline of when you make complaints, what does that process look like to make sure -- you know, we're following as you guys tell us here's the regulations. This is what we should do. We're working. Everybody is tired. We haven't got an increase.

I missed -- I'm apologizing. My link wasn't working, so I didn't get to hear that update on if you had good news or not. But I

think we're just all getting really frustrated and burnt out at this point.

MR. DEARINGER: Sure. Is there anybody on from the MCO branch that would like to talk about that process or MCO division?

MS. SHEETS: Justin, I don't think they're -- I don't think anyone is on to --

MR. DEARINGER: Okay. Okay. So I don't know the exact process. That's not my division. But I will have somebody reach out. Probably the best way to do it would be to reach out to the TAC. Send it to the TAC. Outline the process and then they can kind of send it out and let everybody on here see what the process is. So I think that would be -- that would be a big plus for everybody to kind of see the steps and processes that they go through.

You know, you have to remember that those complaints are coming from every single provider type for all the MCOs. So there are a lot of those complaints that they are getting, and it's not a huge division. But they can let you know kind of time frames and

roughly the exact process and rough time frames anyway, so you'll have an idea.

MS. SAGESER: One of the -- I was going to say one of the comments that was made was when they go to file a complaint -- so when my revenue cycle manager goes to file a complaint, it only is for, like, one claim. So, again, she has a thousand here. So what she did was in the comment section put that it was related to multiple claims.

But, you know, that's also an issue on, you know, just making sure if you're updating the portal or something, just know, like, it doesn't allow you to put in how many claims or multiple claims. There's a comment section, but I don't know how much that helps there. Because you have to put in a claim number for one claim, not multiple.

MS. MARSHALL: I would agree, Renea. We've filed quite a few complaints. And, usually, the issues like Renea's company experienced are not our errors, not the provider error. It's the system error in the MCO. And it is -- it's challenging because we have so many MCOs, and you can have

projects with every single MCO going on. So when there's another one, like this issue with Humana, it's just a compiling effort, you know. It's compiled on the provider, meaning we have multiple projects with multiple MCOs going on. And it just causes that much more nonpayment.

And I think that's our issue as a provider. When we don't do anything wrong and it's some system error like this that's kicking our providers out, paying out of network, you know, then it's just a fight to get all of those claims paid and in full. And any time you have a project, there's fallout from the project, and you have to follow those up.

And so there's not a lot of support on the provider side. To have to wait to get paid 90 days after a recoupment that you did nothing wrong seems unacceptable as a provider. It's just -- because, you know, what happens is we, the little provider, have to go borrow money and pay interest on that and then we don't even get paid interest half the time from the MCO.

You know, it is -- I wish there was a better recourse, a better way that prompt payment could be enforced in a situation like this.

CHAIRMAN LYNN: It is problematic and costly.

MS. SAGESER: That's all I had.

CHAIRMAN LYNN: Any other issues that the TAC or the public would like to speak of?

MS. WILSON: Renea, you said you missed the update on the --

MS. SAGESER: Yes.

MS. WILSON: -- fees. Yeah. There's no new information other than whatever needed to be submitted to the governor was submitted and -- but the Department of Medicaid is still working on, I guess, the more detailed aspects of it because they're doing specific codes and, you know, their rate recommendations and all that. So that is still in process, that part of it.

But the other part that was due in July, my understanding, is that that was submitted;

right, Justin? Did I sum that up pretty basically? Okay.

MR. DEARINGER: That's exactly correct, yes. Yeah. I wish we had it in the budget to just do a broad increase percentage-wise. But fiscally, that's not -- you know, there's no way we can do that fiscally. So we have to look at each code, and codes are very different.

So to be fiscally responsible, we have to look at each code. Because some codes are above what -- you know, what our averages are out there and then a lot are below. So we just have to -- we can't -- you know, we have to take those individually, and it just takes some time. But we're getting there. I know it's frustrating, but we're getting there.

MS. WILSON: I know this is probably completely a guess on your part, Justin. But is it likely, unlikely that we will actually see this update before the end of the year?

MR. DEARINGER: I couldn't -- I couldn't speculate. I don't know the answer to that.

MS. WILSON: Okay.

MR. DEARINGER: I did want to bring up one issue if -- I don't know when it's time for me to do that or not. But can I bring something up really quickly?

CHAIRMAN LYNN: Sure.

MR. DEARINGER: So I had mentioned that provider letter that's going to go out that's got two of the issues on there. It actually has a third issue on there that I wanted to make sure that you all are kind of aware of.

So for outpatient therapy assistant billing, CMS has sent us guidance that we are required to follow, and so we will be sending that out with -- claims that are billed for outpatient therapy services are going to be required to use a CO modifier when they're furnished by an OTA or CQ modifiers when they're provided by a PTA.

So -- and we have that kind of broke down for you in that provider letter, also, so it's going to be a fairly -- I guess maybe a three-part -- a three-part letter or three separate letters. I'm not sure exactly how

they're going to do it. But, I mean, the way I sent it up was a three-part letter. So if they choose to break that down on upstairs, then maybe but --

MS. MARSHALL: Justin, it's Pam Marshall. Wasn't that -- that was put out by CMS a couple years ago, so I would assume everybody should be doing that. I'm not sure if everybody follows the rules but --

MR. DEARINGER: Yeah. Not everybody has been doing it, I don't think, so --

MS. MARSHALL: Yeah. It's been for quite a while.

MR. DEARINGER: Just kind of a clarification because we just changed the system that it will require it. So any time we do that, we have to let you all know so that when you bill differently, it's not going to pay.

CHAIRMAN LYNN: Yeah. I think that modifier was addressed probably two or three years ago, like Pam said. So people should already be doing it, but it's a good idea to remind them to do it.

MR. DEARINGER: Well, any time we make a system change that eliminates things that people have been doing, we always have to let you all know so...

MS. MARSHALL: Yeah. And I'm not sure -- I don't know if the MCOs can speak to this. But have you all -- MCOs, have you done audits on that issue?

MR. OWEN: This is Stuart Owen with WellCare. I do not know. I don't recall, but that's not where my day-to-day responsibilities are. So I honestly don't know. I can check if y'all would like.

MS. MARSHALL: Yeah. I'm just curious if that is a problem, and I would suspect the only way you would know it is if there's a high number of claims for one OT.

MR. OWEN: Yeah. And, I mean, I have not heard of that, so I'm kind of thinking it's probably not a problem.

MS. MARSHALL: Or it's not been looked at because, you know, claims would be billed under an OTR or under a licensed occupational therapist for a COTA. And so you may not know unless you audited and saw

that the COTA's name was on the note, but the OT was on the -- you know, the only way to pull that is if there's a high volume of claims for an OT.

Like, an OT typically doesn't see much more than around 30 to 32 patients a week. And if they had a higher volume, then -- or a PT, PTA, then you would know that they had assistants under them.

MR. OWEN: Yeah. I definitely have not heard of us, like, pulling medical records to audit for that.

CHAIRMAN LYNN: Okay. Any more issues?

MS. DEROSSETT: Renea, you're muted.

MS. SAGESER: Sorry. I'm having to use my phone versus my computer, so it's hard to move it.

So, Justin, I just had a question. So since I missed parts of first of the meeting, which I am really sorry, the letter that you're referring to -- which, yes, I agree with Pam. We do the same thing with our codes on the modifiers. We've already been

using those.

But was there new information on that0 letter going out? And if so, you don't have to go over it. But when is the letter going out so that we can look at it?

MR. DEARINGER: It will be out this week or next week for sure.

MS. SAGESER: Okay. All right. Thank you.

CHAIRMAN LYNN: Okay. I don't suppose there's any recommendations for the MAC.

So the next Therapy TAC meeting will be Tuesday, September 12th.

Thanks, everyone, for attending and for all your updates.

(Meeting concluded at 9:13 a.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 31st day of July, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR