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

****

Via Videoconference
May 12, 2023
Commencing at 8:30 a.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dale Lynn, TAC Chair

Renea Sagaser

Emily Sacca

Kresta Wilson

Linda Derossett

1 MS. BICKERS: She's the only other
2 one I have logged in so far. It looks like
3 a bunch of people popped into the waiting
4 room, though.
5 Okay. It's just now 8:30, but we
6 will give it another minute or so to clear
7 the waiting room.
8 MR. LYNN: Yeah, I still don't see
9 anybody in here besides Kresta.
10 MS. BICKERS: I don't either, and we
11 have cleared the waiting room. So if you
12 would like to go ahead and start, we have
13 been giving some friendly reminders to all
14 of the TACs. All voting members must be on
15 camera while voting. And also, we've been
16 having some issues with the court reporter
17 being able to capture some of the
18 conversation if people are talking over top
19 of each other, so we're just trying to
20 remind each other -- or everyone to try to
21 use the hand-raise button, you know, to the
22 best of our ability.
23 And so we're just reminding everybody
24 of those few things. And the waiting room
25 is clear, Dale, so if you would like to go

1 ahead and start, I only still have two
2 members on, but if you get more members, I
3 can always let you know.
4 MR. LYNN: Okay. I appreciate it.
5 Good morning, everyone, and thank you for
6 joining the Therapy TAC meeting. We only
7 have two members on at this current time;
8 it's myself, Dale Lynn, and Kresta Wilson.
9 Hopefully -- I know that Emily is going to
10 be out. She did give me a notice of that.
11 MS. BICKERS: I think Linda is
12 joining. It just says "Linda" on the name.
13 MR. LYNN: Yeah.
14 MS. BICKERS: So as soon as they get
15 logged in, we'll see if that is --
16 MR. LYNN: Okay. Yeah, it usually
17 does just show her first name.
18 MS. BICKERS: Okay. I think she's
19 logged in. Linda, are you -- there she is.
20 Yep, there you go.
21 MR. LYNN: Perfect. Thanks, Linda,
22 for joining. So we do have a quorum. Three
23 out of the five members we currently have,
24 so I'd like to, first of all, start off with
25 reviewing the March 14th minutes. Kresta

1 and Linda, have you had a chance to review
2 those?
3 MS. WILSON: Yeah. Everything looks
4 good on my end.
5 MS. DEROSSETT: Good.
6 MR. LYNN: Yeah, I reviewed those
7 minutes myself, and I didn't attend that
8 meeting, but I would say that we can approve
9 those.
10 MS. WILSON: Yeah, I'll make a motion
11 to approve.
12 MR. LYNN: Linda, did you get a
13 chance, Linda, to review those minutes?
14 MS. DEROSSETT: I had to unmute.
15 I'll second.
16 MR. LYNN: Okay. Thanks. Old
17 business: The first item is a follow-up
18 from the Department of Medicaid Services.
19 What are the department's study findings on
20 increasing the PT OT speech fee schedule?
21 And I met with Justin Dearinger on Friday,
22 and we had a conversation about that, and I
23 believe the department has a July 15th
24 deadline to complete their study. And they
25 are -- they have studied the fee schedule,

1 plus the first steps fee schedule. So the
2 fee-for-service fee schedule and the first
3 steps fee schedule, and the governor has
4 given Medicaid a directive to have that
5 completed by July 15th, so that's
6 encouraging.
7 Is Justin on the call today?
8 MR. DEARINGER: Yes, sir, I'm here.
9 Can you hear me?
10 MR. LYNN: Yeah, how are you, Justin?
11 It was nice to meet you last week.
12 MR. DEARINGER: Yes, sir. Thank you,
13 and very nice to meet you, too. Yep, as we
14 discussed, you know, we did an internal
15 study initially, reviewing the Medicare
16 rates, looking at them -- all the other
17 states that are surrounding Kentucky,
18 looking at the different types of therapy
19 that's given by different providers. We
20 looked at waiver. We looked at EPSDT. We
21 looked at all the other therapy provider
22 types.
23 So we grouped all those findings and
24 what we are currently paying, what our rates
25 are versus what all those other surrounding

1 states pay, and then we looked at all three
2 different providers that provide therapy, or
3 the provider-type they were enrolled in, and
4 the rates that they were being paid.
5 So we had that study complete, and
6 then we decided to do a little more in-depth
7 study, and look at other states that have
8 similar demographics to Kentucky. Look at
9 some private insurance rates and some other
10 factors. So we actually contracted a
11 contractor to do that more in-depth study
12 and as soon as that one's done, we'll kind
13 of combine those two, go through the data
14 and information, do some fiscal analysis,
15 and see exactly what we can do, and what
16 needs to be done.
17 So that rate study is not completed
18 yet. So that's kind of where we are with
19 that one.
20 MR. LYNN: Thank you, Justin. It
21 looks like you made a lot of progress on
22 that. I appreciate it. Any other comments
23 around that topic?
24 (No response.)
25 MR. LYNN: The next thing on the old

1 business on the agenda is to follow up on
2 Medicaid requiring physician signatures on a
3 plan of care before approving prior
4 authorizations. We discussed that, also,
5 Justin, last week. And I was wondering what
6 the progress is on getting a response, and I
7 understand that the signatures on the plan
8 of care are -- were from an interpretation
9 of/in collaboration with a physician. And
10 I'm just wondering what the policy is
11 regarding that.
12 MR. DEARINGER: Yes, sir. So that
13 was the interpretation of that part of the
14 regulation at the time. And so what we've
15 done is we've created a decision memo. We
16 did some research looking at, again, some
17 language from some other states. We looked
18 at some different insurance company
19 procedures throughout the United States, as
20 well. We compiled that into a decision memo
21 and have just sent that up to the
22 commissioner's office for review. So as
23 soon as we get a decision back from that, we
24 will let you all know what that decision is.
25 MR. LYNN: Okay. Well, I'll follow

1 up on that.
2 MR. DEARINGER: Yes, sir.
3 MR. LYNN: Thank you.
4 The third thing on old business is
5 credentialing concerns, streamlining
6 credentialing process with MCOs. I believe
7 it was Stuart, maybe, that talked about this
8 at the last meeting --
9 MR. OWEN: Yes.
10 MR. LYNN: -- regarding using
11 Verisys. I'm not sure how to pronounce
12 that; I apologize.
13 MR. OWEN: Yes. Stuart Owen with
14 WellCare. And so luckily, there was another
15 TAC that had an update on this yesterday.
16 The Kentucky Hospital Association --
17 MR. LYNN: Mm-hmm.
18 MR. OWEN: -- and Verisys, and they
19 -- somebody from the KHA who spoke and
20 mentioned that there are three MCOs, which
21 are WellCare, Aetna, and Molina, who they
22 will go fully functional with in July --
23 this is what they announced. And they've
24 hired somebody else at KHA with the goal of
25 getting the other three MCOs on board by the

1 end of the year, but it's not live yet.
2 But for those three, they indicated.
3 So, I mean, we'll see, but in July, it will
4 begin for those three. And by the end of
5 the year, they'll have them all on board,
6 and we'll see, but that's the update. It
7 was yesterday. It was actually yesterday
8 that they gave that update.
9 MR. LYNN: Well, that's great to
10 hear. So will a person, once credentialed,
11 would they just go to Verisys, or would they
12 go to the MCO and then be directed to
13 Verisys?
14 MR. OWEN: Yeah, my understanding is
15 it will all be with Verisys. It's a
16 credentialing alliance, is what it's called.
17 MR. LYNN: Mm-hmm.
18 MR. OWEN: It's KHA and Verisys, and
19 I think the MCOs' site would direct you
20 there. If you started with the MCO, you
21 would get routed to the alliance. And so it
22 will all be done through the alliance, is my
23 understanding.
24 MR. LYNN: Yeah, that sounds like
25 it's going to really help to streamline it

1 because I understand Verisys is a pretty
2 good credentialing agent to work with.
3 MR. OWEN: And there was legislation
4 you may or may not be aware of during this
5 past session, you know, because the goal was
6 for all MCOs -- or the hope was that all
7 MCOs would sign, and it basically says if
8 they -- if all the MCOs don't sign with the
9 alliance by the end of the year, the
10 Department of Medicaid Services would have
11 to procure -- issue an RFP for a singling
12 credentialing organization, which is kind of
13 where we started about four or five years
14 ago, I think.
15 MR. LYNN: Mm-hmm.
16 MR. OWEN: So there's legislative
17 pressure, as well.
18 MR. LYNN: Right. Well, I sure
19 appreciate your input on that.
20 MR. OWEN: Yeah, you're welcome.
21 MR. LYNN: Does anyone else have
22 anything on that topic?
23 MR. JAMES: Yes. This is Dr. Tom
24 James with Passport Health Plan by Molina.
25 MR. LYNN: Mm-hmm.

1 MR. JAMES: Just to clarify with
2 Stuart, 'cause he and I used to work
3 together, each health plan under NCQA still
4 has to have its own credentials committee.
5 But what we'll do is be gathering all of the
6 information. I verified yesterday that we
7 were going to be all set with Verisys.
8 MR. LYNN: That is good news.
9 MR. JAMES: Yeah.
10 MR. LYNN: Thank you for your input.
11 MR. JAMES: Okay.
12 MR. LYNN: The next thing on old
13 business is that Anthem is not paying for
14 CPT code 96112, developmental testing. Has
15 this -- there was discussion at the last
16 meeting about this, but I think it may have
17 been resolved; is that correct? Is anyone
18 from Anthem on the call that can address
19 that?
20 MS. MILLER: This is Vicki with
21 Anthem, and yes, we did. We searched our
22 claims going back to dates of service from
23 (indiscernible) --
24 (Inadvertent interruption.)
25 MS. MILLER: -- and we did not find

1 any issues with payment for this code. So
2 if there is anyone that has a particular
3 issue with payment somehow, please don't
4 hesitate to reach out to your provider rep
5 and/or provide us the particular issue. We
6 are happy to look into it, but in our
7 research, we could find no issues with this
8 code.
9 MR. LYNN: All right. Thank you very
10 much.
11 Well, the next thing on the agenda is
12 -- actually, we covered that on the second
13 part of old business. So the last thing on
14 the old business agenda is a follow-up with
15 the department permitting Humana MCO EviCore
16 to create their own medical necessity
17 criteria.
18 MS. KAUFFMANN: Good morning. This
19 is Kathy Kauffmann from Humana. Can you
20 hear me?
21 MR. LYNN: Sure can. Thank you.
22 MS. KAUFFMANN: Okay. Thank you.
23 Yes, and follow-up to this, after the
24 concerns were raised primarily by Marshall
25 Pediatric on our last meeting, we did

1 follow-up. It was confirmed on that meeting
2 that EviCore was able to submit their
3 clinical guidelines to the department, which
4 was done prior to our go-live, and that was
5 approved. And we did -- Humana and EviCore
6 did provide educational training prior to
7 seminars -- prior to and one after our
8 go-live utilizing EviCore to complete our
9 therapy authorization request.
10 We did also provide a link to the
11 department afterward to Evicore's website,
12 which they can access directly the clinical
13 guidelines. And then also the PowerPoint
14 that was provided, too, during the trainings
15 is published on our provider website, and we
16 also provided the link for that. Our
17 provider relations representative, Pam
18 Trigilio, did set up a meeting, and we met
19 with Pam Marshall and her team, including
20 the EviCore team, on March 22nd. And at
21 that time, we did address their concerns and
22 reviewed any questions they had on
23 individual authorizations and denials.
24 We left -- the conclusion is that
25 they were going to review the information

1 that we had provided to them and would
2 request another meeting if necessary, but we
3 have heard no further concerns.
4 MR. LYNN: So my question would be
5 that I was under the impression that it was
6 InterQual and Milliman were the two criteria
7 that need to be met for medical necessity.
8 And can somebody from Medicaid respond on
9 why they would allow an MCO to create their
10 own criteria?
11 MS. KAUFFMANN: Just to clarify,
12 Dale, Humana did not create the clinical
13 criteria. This is EviCore's proprietary
14 clinical criteria, and it was submitted, as
15 I said, to the department. Angie Parker did
16 confirm on the last call that MCOs are able
17 to submit additional clinical criteria for
18 review and approval, and this was completed
19 before we went live.
20 MR. LYNN: Well, I guess my question,
21 then, would be to Angie if she's on the
22 call. Why would the department allow an MCO
23 to create their own criteria -- or not an
24 MCO, or EviCore, rather?
25 (No response.)

1 MR. LYNN: Is there something in the
2 regulations that maybe I'm missing, or
3 anybody else on this call is missing that
4 would allow them to create their own medical
5 necessity criteria?
6 MS. BICKERS: I don't see Angie on
7 the call, but I can take that back and
8 follow up with you.
9 MR. LYNN: Okay, thank you.
10 MR. GERALDS: This is James with DMS.
11 I'll go ahead and take that question. There
12 is some latitude in the current regulation
13 that MCOs have to add additional criteria
14 beyond the existing regulation. So what
15 Kathy was referring to is that they have a
16 contract with EviCore to administer that.
17 So I can definitely -- Dale, I can
18 definitely get that regulation to you and
19 your team so you guys can follow up on that.
20 MR. LYNN: Yeah, that would be great,
21 James. If you can, send that criteria to
22 the Therapy TAC members so we can review
23 that and the regulations and take that up.
24 MR. GERALDS: No problem. No
25 problem.

1 MR. LYNN: Thank you.
2 MS. CANTOR: Did you want me --
3 MR. LYNN: Dr. Cantor --
4 MS. CANTOR: Yes, good morning.
5 Thank you. I'm Dr. Cantor with United
6 Healthcare, the CMO. And if I've been
7 following this conversation correctly, and
8 my understanding of the contract, MCOs are
9 allowed to create -- we are allowed to
10 provide utilization management. And if
11 InterQual does not speak to the specific
12 subject matter at hand, we are allowed to
13 make medical clinical guidelines in all
14 conditions that follow the standards of
15 care. Those clinical guidelines at United
16 Healthcare are overseen not by just United
17 Healthcare subject matter experts, but they
18 are overseen by various experts,
19 professional societies, non-UHC associates.
20 So they are not driven -- they are not
21 completely written and overseen by
22 associates at UHC.
23 So we are allowed to write policies,
24 especially when InterQual may be silent.
25 And then those policies are submitted to DMS

1 for their approval, and any third party,
2 like EviCore -- we also use EviCore. We
3 submit those policies on a very -- on a
4 monthly cadence because each policy gets
5 reviewed annually for any medical updates,
6 and they are submitted to a specific state
7 SharePoint site.
8 So if I followed correctly, and
9 having worked at other MCOs, that's
10 typically the process. MCOs are allowed to
11 adjudicate and write -- they are allowed to
12 adjudicate based on medical policies that
13 are created by the medical policy committees
14 at our MCO. I hope that made sense.
15 MR. LYNN: Yeah, it does, Dr. Cantor,
16 and I look forward to reading the regulation
17 around that. Thank you.
18 MS. CANTOR: Sure, sure. It's in our
19 contract, and I could send you that section
20 on utilization management if you would like.
21 MR. LYNN: I would. I would
22 appreciate that, Dr. Cantor, if you would.
23 Thank you.
24 MS. CANTOR: Absolutely.
25 MR. LYNN: And, Pam, I think you have

1 your hand up now; is that correct?
2 MS. MARSHALL: Yes, I do. So the
3 question we didn't get answered, Dale, is
4 what is it in the, you know, Milliman or
5 InterQual criteria that were not met? What
6 was it that wasn't met that forced Humana
7 MCO to use EviCore's additional criteria?
8 That's the question that has not been met
9 when we've, you know, asked that over and
10 over.
11 We're just trying to understand how
12 did it come to this because the regulation
13 was written so there would be a uniform kind
14 of standard, and that, you know, insurance
15 companies couldn't just, on a whim, make up
16 different criteria? So we just want that
17 question answered. What was it that was not
18 met that allowed for this extra criteria?
19 MS. KAUFFMANN: So this is Kathy
20 Kauffmann again. It's not that -- we had
21 previously been reviewing our therapies
22 prior to our contract with EviCore going
23 live utilizing MCG guidelines, but as
24 everyone is familiar with and has already
25 been stated, in some instances, InterQual

1 and MCG do not provide, you know, detail for
2 some, you know, request or conditions. When
3 we entered into the contract with EviCore,
4 they did share their clinical guidelines
5 that they have created utilizing best
6 practices and, you know, the most current
7 information.
8 These clinical guidelines were
9 submitted to the department prior to our
10 go-live, and they did approve those for use
11 in our therapy request. But it really
12 wasn't that, you know, we felt like MCG was
13 not appropriate for use. It's just that
14 EviCore did have their much more specific
15 clinical guidelines that were proprietary to
16 their company that they had been using, and
17 it was approved.
18 And those guidelines are available,
19 and there is a link on EviCore's website
20 that they're able to be accessed. So if
21 there are specific questions about that,
22 then you can definitely review that. Again,
23 Pam, if you have any questions specific on
24 any authorization denials, we are happy to
25 do the research with EviCore and discuss

1 those on another call.
2 MS. MARSHALL: Okay. I'm just
3 wondering if there's a conflict here from
4 between the regulation that the providers go
5 by and the contract between the MCO and DMS.
6 Because the language in the regulation says
7 that if it is determined that a medical
8 necessity criteria is not available or is
9 not specifically addressed for a service or
10 for a specific population, the contractor
11 shall submit its proposal for medical
12 necessity criteria for approval.
13 So in our minds, as the provider,
14 there has to be, you know, either not
15 available or it's not specifically
16 addressed. There has to be a reason that
17 additional criteria is created, and that's
18 the way we read it. We don't necessarily
19 know the contract language between the MCO
20 and DMS, but it's a conflicting -- from a
21 provider standpoint, this is conflicting.
22 And that's what we're -- as a group, as a
23 whole, we're requesting that this be cleared
24 up because, you know, we're asking what is
25 the specific criteria that wasn't addressed

1 that allowed for additional criteria to be
2 developed or used?
3 Even though it says, you know, the
4 department may require the use of other
5 criteria, and it creates or identifies for
6 services or populations not otherwise
7 covered by the name criteria in this
8 section. That's the language in the reg.
9 So we're requesting that someone look at the
10 regulation that we follow and see if there
11 is conflicting information here.
12 MR. DEARINGER: Hi, this is Justin
13 Dearinger. I appreciate the conversation,
14 and I know -- I understand the issue. So
15 let me take this back. Again, we have a
16 current decision memo on signatures
17 verifying doctor cooperation. Let me put
18 this in that same format, do some research,
19 and submit that, so we can get you all a
20 definitive answer from the Department for
21 Medicaid Services, if that would be okay.
22 MS. MARSHALL: Yes, that would be
23 okay.
24 MR. DEARINGER: Okay.
25 MR. LYNN: Yeah. That would be very

1 helpful, Justin; appreciate it.
2 Okay, onto new business. A Kentucky
3 provider brought up a concern regarding a
4 patient who is insured with an MCO and is
5 being evaluated for disability. The MCO
6 realized that this person was being
7 evaluated about six months or a year ago,
8 beginning the evaluation process, and
9 realized that when the individual is in the
10 disability evaluation process, they default
11 to traditional fee-for-service Medicaid.
12 And so the MCO retrod back to the beginning
13 date of when this person was -- again, their
14 evaluation process, and recouped payments,
15 and this person was defaulted to Kentucky
16 Medicaid.
17 So the problem with that is the MCOs
18 have different criteria for prior
19 authorizations than Kentucky Medicaid has.
20 Kentucky Medicaid requires an authorization
21 to be 90 days, not 91 or 89. They require
22 the physician signature to be on the plan of
23 care within 30 days of the service. And the
24 MCOs have different, you know, more lenient
25 requirements than -- most or all of the MCOs

1 don't require a physician signature on the
2 plan of care, for one.
3 So this is problematic. Whenever
4 this provider went to Medicaid to retro back
5 their authorizations, which the wonderful
6 thing about Medicaid is they will go back a
7 year and retro-auth. But the criteria is so
8 different that it is so problematic for a
9 provider to be able to capture all of that
10 -- those dates accurately. And I guess what
11 the TAC is requesting is that Kentucky
12 Medicaid just honor the authorizations that
13 the MCO gave at that time. And then, from
14 that day forward, go by Kentucky Medicaid's
15 policies on prior authorizations. Does that
16 all make sense?
17 MR. DEARINGER: Yes, sir. That
18 absolutely makes sense. I understand, you
19 know, what you're asking. At this time,
20 however, I think in our administrative
21 regulations and our policy and procedures,
22 we have different criteria. So we would
23 have to follow that unless we did a change
24 -- unless we made a change to that.
25 And I think part of the last

1 statement that we discussed, we can also
2 discuss the possibility of making some sort
3 of change in that circumstance. I'm not
4 sure, you know, usually if -- especially if
5 it's an administrative regulation, once it's
6 set, it's set until it's changed. And that
7 can be up to a year-long process to get that
8 changed. If it's something that's in
9 policy, then we can review and make a change
10 to that, but what we won't be able to do is
11 to be able to do -- I think what you're
12 asking for here -- the reason for that is if
13 we have our criteria set in policy -- if
14 it's in regulation our hands are tied until
15 that regulation is changed. That's state
16 law. If it's in policy, we can review that
17 and make a change, but that has to be the
18 policy for all cases that are brought to us.
19 That has to be -- the criteria has to be
20 the same for all prior authorizations for
21 traditional Medicaid. So it's not a big
22 deal for us to look at that, reevaluate
23 those policies, and make changes to those
24 policies, but it has to be the same for
25 everybody all the time.

1 So having said that, we do give MCOs
2 a little leeway, some flexibility to be able
3 to serve their members the best way they
4 feel possible. And so that makes the
5 criteria a little different. As you said,
6 it's allowed a lot of the MCOs to be more
7 lenient with things like provider signatures
8 and some of the other requirements that we
9 have for fee-for-service traditional
10 Medicaid, but because we allow them all to
11 be different, we're not able to adjust to
12 each one's own specific requirements for
13 prior authorizations. So if we were to do
14 that, then we would have no real set
15 criteria ourselves.
16 I hope that makes sense, and I
17 understand the dilemma that you all are
18 having with that. I'm hoping that by
19 looking at the signature requirement, we can
20 ease some of that, but I think we won't be
21 able to ease all of that due to making sure
22 that we have an actual policy in place that
23 sets criteria. And we can't really make
24 that flexible for each MCO. I hope that
25 makes sense.

1 MR. LYNN: Yeah. I understand,
2 Justin, but the situation is what's the
3 provider doing when they provided a service
4 for maybe up to a year, and then they were
5 never notified that -- by Kentucky Medicaid
6 that this member prompted back to Kentucky
7 Medicaid for their insurance? So, you know,
8 why doesn't Kentucky Medicaid notify the
9 provider when that happens? Or do they not
10 know themselves -- Medicare? See, that's
11 the real dilemma.
12 MR. DEARINGER: So without knowing
13 the specifics, I don't know exactly what
14 happened or when, but if you could -- if you
15 will e-mail me the specifics after the
16 meeting. Because we do look back on a
17 case-by-case basis, if something happened,
18 that was our fault, or that was out of the
19 control of the provider and MCO, and it's
20 something that we can go back and look at
21 and fix. We do look at those. At least
22 weekly, we get cases, like, similar, maybe
23 not the same, but we get cases where things
24 have happened. So if you can get with me
25 after, or somebody can after the meeting and

1 send me some specifics, we can research that
2 and see what we can do.
3 MR. LYNN: Sure. I will be happy to
4 get with you, Justin. And I will contact
5 that provider that notified me about this
6 situation, and we'll both speak with you,
7 but that is a real issue about the provider.
8 I had no idea that, you know, their patients
9 got defaulted back to Kentucky Medicaid, and
10 they provide these services and aren't going
11 to get paid for them. So --
12 MS. MARSHALL: Dale, can I add to
13 this?
14 MR. LYNN: Sure.
15 MS. MARSHALL: Can I speak? Okay.
16 So our practice -- I'm not sure if anyone
17 else --
18 MR. LYNN: This is Pam Marshall,
19 right?
20 MS. MARSHALL: Yes, Pam Marshall.
21 We've had four cases from WellCare, and one
22 of them dated back more than a year. And
23 here's a couple problems that if you can
24 investigate the provider's screen with what
25 the provider sees because there's no date on

1 the provider screen of when Medicaid changed
2 that retro because we check Medicaid often
3 and verify Medicaid, you know, all the time
4 when a patient is coming in.
5 So this was a retro situation of four
6 patients. One goes back more than 13
7 months. So the regulation, you know, what
8 happens when we need a prior auth for that
9 month that's beyond the year from the
10 regulation? You know, we need to get paid
11 in this situation because we have
12 screenshots of what we see, and this
13 information was not available until more
14 than a year -- it retrod more than a year
15 back.
16 And this used to happen a lot in
17 2014/2015 when we were new provider types,
18 but it hasn't happened for many years. And
19 I don't know if this was a fluke thing, but
20 we can give you the four examples we had as
21 a reference. And I don't know if anyone
22 else in the state is experiencing this same
23 thing, but, you know, the MCOs are quick to
24 recoup that money, and then the provider is
25 sitting, waiting to get prior auths to be

1 able to submit those claims. You know, and
2 especially, many of these children are
3 receiving multiple services, so it's
4 hundreds of claims, and it's a big
5 administrative burden when this happens, as
6 well.
7 So any help to streamline this
8 process and to help us, the provider,
9 understand, are more of these coming? Like,
10 what triggered this, and do we expect there
11 to be more of them where this was missed?
12 Because our practice alone gets probably 10,
13 15 requests a month for disability, you
14 know, submitting records for disability. So
15 what is happening when those children are
16 going through that disability determination?
17 Should we expect and proactively expect them
18 to flip to fee-for-service Medicaid?
19 That's what we need to understand as
20 providers, and I think there may need to be
21 an additional column on the screen that
22 shows when that retro was added to KYMMIS.
23 And I know if you're switching systems -- is
24 it in the new system? Does it show when
25 Medicaid -- when DMS personnel added that to

1 the computer? You know, is there a date
2 because people are going by different dates?
3 When we are trying to submit a PA, they have
4 a different date than what we have or what
5 we see.
6 MR. DEARINGER: Yeah, that makes
7 complete sense, and I know that used to be
8 an issue, and I'm not sure why it's starting
9 to pop up more, but we'll (inadvertently
10 muted.)
11 MR. LYNN: Thank you, Justin. We'll
12 continue to communicate with you on that
13 subject, and hopefully, we can get Kentucky
14 Medicaid to have some flexibility on their
15 prior authorization approvals under those
16 circumstances. Is there any other
17 discussion on this topic?
18 MS. DEROSSETT: The only thing that I
19 have is -- this is Linda Derossett. But
20 when you were talking about the retros, and,
21 you know, one will retro and one won't
22 retro. I just think that, you know, maybe
23 we can look at that, or maybe the MCOs could
24 look at that and be more consistent with
25 being able to retro a few things or at

1 least, you know, a few days or anything like
2 that. Because it seems to me that when
3 we've talked through some of the meetings
4 that there's been errors maybe made by the
5 MCOs that have had to, you know, wait on
6 payment or wait on, you know, recoupment by
7 the providers, although there's no leeway
8 for the provider to make an error and have
9 to retro.
10 So I think that, you know, it's kind
11 of a two-way street, that if we're giving
12 leniency to the MCOs to make an error and
13 come back and pay us later, then there
14 should be a little bit of leeway on the
15 provider's part to make an error or miss a
16 deadline and go back and recoup that because
17 I don't think that we're trying to cheat the
18 system. We're trying to treat the children,
19 and we're trying to do the best we can, and
20 there's some things that fall through the
21 cracks, and I think there should be a little
22 bit of leniency there. If we're, you know,
23 doing it back-and-forth, I think that needs
24 to be addressed. I don't know if anybody
25 agrees with me.

1 MR. LYNN: Yeah, I certainly agree
2 with you, Linda. I've had to request some
3 retro-auths, and some of the MCOs are fairly
4 lenient on that, and some are not. Any
5 other discussion on that? If not, we'll
6 move to the last item that I have on the --
7 that the TAC has on new business.
8 (No response.)
9 MR. LYNN: A Kentucky provider
10 reported that United Healthcare has removed
11 the CPT code 97533, which is sensory
12 integrative techniques, as a covered code.
13 And I was wondering if a UHC --
14 MS. CANTOR: Sure. Good morning
15 again. Yes.
16 MR. LYNN: Thank you.
17 MS. CANTOR: Hi, Dale. This is
18 Dr. Cantor with United Healthcare.
19 MR. LYNN: Yeah.
20 MS. CANTOR: I appreciate the agenda
21 being put forth, I think, last week. It
22 gave us an opportunity to review this in
23 advance, so I really do appreciate the
24 notification with the agenda.
25 Actually, 97533 has been removed from

1 the prior auth, so it's not that it's not
2 covered. It's that it doesn't require a
3 prior auth anymore. It's still a covered
4 code, and it's available. It's just the
5 administrative burden of the prior
6 authorization part has been removed.
7 MR. LYNN: Okay. I understand. I
8 saw in a -- in the provider letter, I guess
9 it was, and it wasn't clear that that's what
10 it stated.
11 MS. CANTOR: Yeah. I'm catching that
12 now. I've got an e-mail from the provider
13 that was questioning this, and it does look
14 like that whoever -- that when we wrote
15 that, it wasn't clearly stated that the
16 prior auth was removed. So I will -- I'm
17 trying to figure out where that bulletin
18 came from, and I'll work on that, but
19 hopefully, everyone on this call, all the
20 providers, have that understanding that it's
21 a covered code. No prior auth is needed.
22 MR. LYNN: All right. I appreciate
23 that clarification. That's what kind of
24 triggered this question was that --
25 MS. CANTOR: Yeah. Yep.

1 MR. LYNN: -- it was rumored that it
2 was --
3 MS. CANTOR: Thank you.
4 MR. LYNN: -- removed from payment.
5 MS. CANTOR: No, no, no, not at all.
6 MR. LYNN: Thank you.
7 MS. CANTOR: The other way around.
8 The other end of the spectrum.
9 MR. LYNN: Yeah. Great. Glad to
10 hear that.
11 MS. CANTOR: Yes.
12 MR. LYNN: Are there any other issues
13 from TAC members or the public on this call?
14 MS. WILSON: Hey, Dale, I have a
15 couple --
16 MS. CANTOR: I thought I saw Pam's
17 hand up.
18 MR. LYNN: Pardon me?
19 MS. CANTOR: I thought I saw Pam
20 Marshall's hand up.
21 MR. LYNN: Oh, okay. I did not see
22 that, sorry.
23 MS. CANTOR: Thank you.
24 MR. LYNN: Pam?
25 MS. MARSHALL: Yeah, I was just going

1 to add to the 97533 and UHC issue is that it
2 was, on the prior-auth end, being viewed as
3 it would be a noncovered code at first, and
4 it was not listed as a covered code on the
5 medical policies. So I think it did -- it
6 appears it got straightened out, and it
7 appears there is language that states
8 Kentucky is the exception for that medical
9 policy that says this code is not covered.
10 MR. LYNN: Gotcha.
11 MS. CANTOR: Where might that --
12 where might you be seeing that?
13 MS. MARSHALL: I can provide the
14 reference to you, Dr. Cantor.
15 MS. CANTOR: Thanks, Pam.
16 MS. MARSHALL: I can send it, yeah.
17 MS. CANTOR: Is that in our bulletin?
18 MS. MARSHALL: Yeah. It came out in
19 the provider communication.
20 MS. CANTOR: Provider network?
21 MS. MARSHALL: Mm-hmm.
22 MS. CANTOR: But is that the
23 confusion that --
24 MS. MARSHALL: Yes, yes.
25 MS. CANTOR: -- because it wasn't

1 listed as the codes that were --
2 MS. MARSHALL: No, it was actually
3 communicated to us as of June 1st, it would
4 not be a cover code.
5 MS. CANTOR: I have e-mails from just
6 a couple weeks ago where our team said that
7 it's -- they will no longer require auth or
8 clinical review, and it's covered. I'll
9 forward that string back to you, Pam --
10 MS. MARSHALL: Okay.
11 MS. CANTOR: -- but I'd like to see
12 what you're seeing, too.
13 MS. MARSHALL: Yeah. There might
14 have been just some confusion about it --
15 MS. CANTOR: Yeah.
16 MS. MARSHALL: -- but I'll send you
17 what we have, all the different bulletins
18 that came out.
19 MS. CANTOR: Thank you.
20 MS. MARSHALL: Mm-hmm.
21 MS. CANTOR: Thank you.
22 MR. LYNN: Yeah, Elizabeth, you had
23 your hand up.
24 MS. RHODUS: Yeah, I did. My name is
25 Elizabeth Rhodus. I'm faculty at the

1 University of Kentucky. I'm also an
2 occupational therapist, and I am joining on
3 the public's behalf. I do a lot of research
4 related to mental health and behavioral
5 health, and we use a lot of different
6 sensory techniques and things like that.
7 But I predominately work with older adults
8 and people with dementia, so I don't want to
9 chime in so much as to new business No. 2
10 related to United Healthcare's reimbursement
11 with the sensory integrative techniques as I
12 do -- just want to speak out to the need for
13 establishing occupational therapy as an
14 approved behavioral health provider so that
15 we can then expand some of our opportunities
16 to provide some of these sensory techniques
17 for neurological and behavioral regulation.
18 I have a slew of research and
19 evidence. We have a million-dollar NIH
20 clinical trial that I'd love to kind of
21 present and talk about. I'm going to have
22 to go in just two minutes for another
23 meeting, but I just wanted to introduce
24 myself to the team and say that we are doing
25 nationally funded work specifically related

1 to sensory-based interventions, and the
2 opportunity and the need to coordinate, in
3 our state, occupational therapy and the
4 approval for behavioral health across the
5 board.
6 So thank you for letting me introduce
7 myself, and I'm gonna put my e-mail in the
8 chat. And I would love to continue the
9 conversation if that's an opportunity.
10 Thank you.
11 MR. LYNN: Yes. Thank you for your
12 input, Elizabeth. Kresta, do you have a
13 question?
14 MS. WILSON: Yeah. I, hopefully,
15 just wanted to get some contact information
16 because I have a few things -- a few
17 questions for someone with WellCare and a
18 few questions for someone with Aetna. So if
19 anybody -- representatives from those two
20 MCOs on this call, if you could put your
21 e-mail in the chat, I would really
22 appreciate it.
23 And then, also, Dr. Cantor, if you
24 can put your e-mail in the chat because I
25 have a feeling we might have some additional

1 things pop up with that 97533 code. Thank
2 you.
3 MR. LYNN: Any other concerns or
4 issues that a TAC member or the public has?
5 MS. WILSON: Is there anybody on the
6 call with Aetna?
7 MS. RISNER: Yes, this is Krystal
8 Risner.
9 MS. WILSON: Okay. Great, Krystal,
10 thank you. Do you care to put your e-mail
11 in the chat for me?
12 MS. RISNER: Yeah, sure will.
13 MS. WILSON: Thank you.
14 MR. LYNN: So it doesn't look like we
15 have any recommendations for the MAC; do we,
16 TAC members?
17 (No response.)
18 MR. LYNN: So if not, our next
19 Therapy TAC meeting is Tuesday, July 11th,
20 at 8:30 Eastern time, and I look forward to
21 seeing everyone then. Thank you, everyone,
22 for attending, and have a --
23 MS. KAUFFMANN: Thank you, Dale.
24 MR. LYNN: -- wonderful day.
25 (Meeting adjourned at 9:20 a.m.)

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3 CERTIFICATE

4

5 I, Tiffany Felts, CVR, Certified Verbatim

6 Reporter and Registered Professional Reporter, do

7 hereby certify that the foregoing typewritten pages

8 are a true and accurate transcript of the

9 proceedings to the best of my ability.

10

11 I further certify that I am not employed

12 by, related to, nor of counsel for any of the

13 parties herein, nor otherwise interested in the

14 outcome of this action.

15

16 Dated this 26th day of May, 2023.

17

18

19 Tiffany Felts, CVR

20 Tiffany Felts, CVR

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