# Annual Medicaid Roundtable
## April 20, 2017
## FINAL WITH RESPONSES

| CONCERNS WITH ALL MCOS | | |
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| **All MCOs Question 1 of 2** | KY Medicaid pays the nursing home for the patient's stay but doctors have to go through the MCO's for payment. Most MCO's will not give retro authorizations. I do not know until the day of or after the fact that the patient has a MCO. How may I back track to get an authorization for the patient? | Lois Sheffield, Dr. Swati M Daftary; Rehabilitation rehabinst1@att.net |
| **RESPONSES:** | | |
| **Aetna Better Health** | 4/20/17: Providers can obtain retro authorizations for up to 24 hours | |
| **Anthem** | 4/20/17: Providers can obtain retro authorizations for up to 24 hours | |
| **Humana CareSource** | 4/20/17: Providers can obtain retro authorizations for up to 180 days | |
| **Passport Health Plan** | 4/18/17: Passport does not require authorization for a MD visit, unless the MD is non-par with Passport. A referral is required from member's PCP for all services that are not direct access (i.e. orthopedics, obstetrical). | |
| **WellCare** | 4/20/17: Providers can obtain retro authorizations for up to 5 days. 4/20/17 Update - WellCare does not require authorizations for E/M Codes in a Skilled Nursing Facility from primary care providers. If there are providers who have denials for services, please forward my contact information as I can help resolve the issues. | |
| **All MCOs Question 2 of 2** | How are the plans going to handle the new KY Medicaid requirement that all Ordering, Referring, and Prescribing Providers are enrolled in KY Medicaid? As an academic practice, our residents (who are enrolled in KY Medicaid) often times prescribe medicine and we want to ensure that patients are not denied that Rx when they arrive at the pharmacy only because the plans don't load residents in their system. | Dayle Benton; University of Louisville Physicians dayle.benton@ulp.org |
| **RESPONSES:** | | |
| **Aetna Better Health** | 4/20/17: All providers ordering, referring or prescribing must have a KY Medicaid MAID number for services to be covered | |
| **Anthem** | 4/20/17: All providers ordering, referring or prescribing must have a KY Medicaid MAID number for services to be covered | |
| **Humana CareSource** | 4/20/17: All providers ordering, referring or prescribing must have a KY Medicaid MAID number for services to be covered | |

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| **Passport Health Plan** | 4/18/17: All Ordering, Rendering and Prescribing providers must have a MAID. If a resident does not have a MAID, then the prescription would need to be written by a supervising physician or other provider who does have a MAID. DMS has created a provider directory that will enable providers to verify that an Ordering, Referring or Prescribing physician is a Kentucky Medicaid provider. Please distribute this website to any provider groups that could benefit from this search tool. https://prdweb.chfs.ky.gov/ProviderDirectory/PDSearch.aspx | |
| **WellCare** | Ordering, Referring, and Prescribing Providers must have a MAID number. | |
| AETNA BETTER HEALTH | | |
| **Aetna Better Health Question 1 of 3** | We are experiencing tremendous challenges with Aetna Better Health of KY loading our practitioners. All other plans load practitioner additions/changes/deletions within 90 days but Aetna Better Health averages a 6 month delay. 4/20/17: They have experienced a loading period of longer than 90 days; they have some physicians from July 2016 that have been credentialed but not loaded. They have contacted their Provider Relations Representative Phil Kemper and have not received any response. | Dayle Benton, University of Louisville Physicians dayle.benton@ulp.org |
| **RESPONSE:** | | |
| Aetna Better Health has a 90 day goal for loading providers into the system; they do realize there have been issues and they expect those issues to be resolved soon. Cathy LaPointe will address the issue with the Provider Relations Representative. Lee Guice will also address the issue through the DMS office of provider representatives not providing appropriate provider support. | | |
| **Aetna Better Health Question 2 of 3** | Our immediate issue is about credentialing. We have one MD who supposedly is "in process" to get back on their roster and I can't get any updates or news. He has been delaying surgeries over this issue. To make matters more frustrating, one of his patients who has been rescheduled for surgery called Aetna and asked about the issue and they told her that they sent us some info and we never replied to them. I have since reached out to Phil again to ask if there was something outstanding that they needed and still have not heard anything back. That was on 3/8 and still nothing from him. The basic provider enrollment phone number takes you straight to VM and no one calls back. Also, I have tried to register for their provider portal since Jan and I have not received anything back. I called and spoke to a CSR from another dept a couple of weeks ago and she said that the process usually takes at most 72 hours. I had to speak to her because no one answered the provider enrollment line. I have never had such difficulty with a major carrier in 13 years doing this. | Lisa Pillow, Advanced ENT & Allergy lpillow@advancedentandallergy.com |
| **RESPONSE:** | | |

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| Cathy LaPointe, Provider Relations Manager stated that Aetna has recognized that one Provider Representative has not been getting back to provider practices. This was addressed with that Provider Rep this week when this issue was received by GLMS. | | |
| **Aetna Better Health Question 3 of 3 (RECEIVED 4/18)** | When Aetna Better Health first took over Coventry Cares of KY, they failed to load allergy codes for their fee schedule. We have outstanding claims since February, 2016 that has been repeatedly promised to us to settle and now we cannot even get a return call from anyone at Aetna Better Health. I send in requests each and every month to the same representatives that stated this would be a claims project due to so many affected practices and that by Jan. 2017 it would be resolved. It has not been resolved and now no one will further assist us in resolving this outstanding balance on dozens of cases. | Theresa McCoy, Kentuckiana Allergy<br>tmccoy@kyaai.com |
| **RESPONSE:** | | |
| Cathy LaPointe stated that Phil Kemper, Provider Relations Representative will follow up as soon as possible. | | |
| ANTHEM MEDICAID | | |
| **Anthem Medicaid Question 1 of 1 (RECEIVED 4/18)** | Anthem Medicaid issued us refund requests for excess visits of 99214 and 99215 without any notice. New policy goes into effect 2/1/17 that states any access of more than 2 visits per 12 months for level 4 and 5 will be downcoded to level 3 and remitted payments will be at level 3 reimbursement. Refund request was for 12/2016 but now Anthem Medicaid states this was an error and will retract the refund request but our issue is that the policy states they will downcode us and remit less than what services were performed and question if they can downcode our services | Theresa McCoy, Kentuckiana Allergy<br>tmccoy@kyaai.com |
| **RESPONSE:** | | |
| Ken Groves, Provider Network Manager stated that after February 1, 2017, when more than two 99214 or 99215 services are billed per patient/ per provider in one year, subsequent level 4 and level 5 visits will be paid at the 99213 rate. | | |
| HUMANA CARESOURCE | | |
| **HUMANA CARESOURCE Question 1 of 1 (RECEIVED 4/18)** | In error, Humana CareSource removed some of our providers from the group and therefore, started denying claims and in addition, referring providers could no longer locate us. Project under way for all Caresource products per representative to get this corrected per email received recently. But no timeframe as to when this will be resolved. | Theresa McCoy, Kentuckiana Allergy<br>tmccoy@kyaai.com |
| **RESPONSE:** | | |

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| Dawn Powell, Health Partnerships Manager, stated that this issue had been resolved this week when this issue was received by GLMS. | | |
| PASSPORT HEALTH PLAN | | |
| **Passport Health Plan Question 1 of 2** | We have approximately 10 procedure codes that are on the CMS Inpatient Only code list however, our Surgeons do these procedures on an outpatient basis. For over a year I have communicated with Rebecca Barbera regarding this situation and have supplied her with the list of codes, an example of a denied claim and patient Op notes. Rebecca had said that the Medical Director at Passport could approve having these procedures done on an outpatient basis but to date, this issue has not been resolved. I last reached out to Rebecca on February 6th with an email and a voice mail message but have not had a return call or email. | Teri Trail, University of Louisville School of Dentistry<br><br>Teri.trail@louisville.edu |
| **RESPONSE:** | | |
| 4/18/17 - Passport clinical management is reviewing these concerns but there has been no decision made yet as to if we will or will not continue the utilization of this list. If the MD feels the procedure can safely be done as an OP or observation for an IP only code, they may submit the records with the claim and our Medical Director will review for appropriateness of the setting; If our Medical director indicates that the procedure was safely performed as outpatient or observation, the claim will be processed and paid. 4/20/17 - Teri said they have been dealing with it for over a year and asked how long it will take to review. They have claims the surgeons have performed that are waiting for payment. Lori said she will meet with Terri at the conclusion of the roundtable. | | |
| **Passport Health Plan Question 2 of 2** | Passport has been denying Gardasil (CPT 90651) for male patients since October, 2016 for "wrong gender". This issue was supposed to have been fixed but has not been corrected to date. | Frances Burton, Pediatric Associates of Louisville<br><br>Frances Shouse Burton (fburton@mw.twcbc.com) |
| **RESPONSE:** | | |
| 4/18/17 - This error has been corrected and our system is currently being configured for accuracy. Once configuration is complete, an audit will be run to capture all missed or inaccurate claims payments. | | |
| KENTUCKY DEPT FOR MEDICAID SERVICES | | |
| **DMS Question 1 of 2** | The length of time to get a Ky. Medicaid Provider ID seems to have gone from 90 days to 120 days. We have new residents that begin seeing patients on July 1st and need to be able to prescribe medications for their patients. For those residents in a one year program, they are almost through their residency before they have a Provider ID. Are there any plans for the state to improve the enrollment system to reduce the turn around time? | Teri Trail, University of Louisville School of Dentistry<br><br>Teri.trail@louisville.edu |

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| **RESPONSE:** | | |
| They should be running on schedule. Lee will check on the current provider enrollment department averages and get back with Stephanie at GLMS. December 2017, Lee replied: Earlier this year, DMS implemented two items which impacted enrollment. One was requiring all order, rendering and | | |
| **DMS Question 2 of 2** | All secondary claims sent to KY Medicaid are not to be processed. Was informed by Medicaid to send only paper claims as they are unable to read any primary EOBs at this time due to a glitch. Is this being corrected so that we can submit secondary claims through Availity? Any estimated timeframe for this to be resolved? | Theresa McCoy, Kentuckiana Allergy<br><br>tmccoy@kyaai.com |
| **RESPONSE:** | | |
| Lee Guice reported that it is her understanding that only certain claims have been affected by this issue. She will get back with Stephanie at GLMS with an update when one is available. December 2017, Lee replied: She has spoken and emailed several people and believes this was resolved earlier this year. If a provider is still having to submit paper claims, she asked to let her know and they will reach out. | | |
| NEW DISCUSSION ITEMS FROM ROUNDTABLE | | |
| **All MCOS/ DMS** | Question was asked why CPT 43520 (Pyloromyotomy) could only be billed as in-patient. Their physicians feel comfortable doing it on an observation status, however, it has to have an authorization code and be done as in-patient. What would the possibility be of moving this to an observation status. | Patti Sacra U of L Physicians-Pediatric Surgery |
| **RESPONSE:** | | |
| Mark Prussian asked all the MCO's and DMS to get back to Stephanie Woods at GLMS with an answer. Lee Guice from DMS replied in December 2017: This procedure can and is performed as outpatient and/or observation status. Mostly done to babies when food and such can't get out of the | | |
| **KY DMS** | Similar scenario with CPT 66984 Cataract Extraction with IOL insertion has had a 5 year demonstration project with CMS for Medicare to move the place of service from outpatient surgery to the physician offices. They generally give a thumbs up but there is a lot more work to it. Mark asked Lee to explain the policy for moving a place of service for Medicaid? | Mark Prussian, The Eye Care Institute |
| (Lee Guice) Generally with codes, DMS will take the lead from Medicare. If Medicare is willing to move the place of service, DMS will look at it but they have to take into account any fiscal impact. Sometimes there is an inpatient rate and an outpatient rate. DMS will look into it but they cannot incur higher costs to change it. Lee invited Mark to email her with the recommendation. | | |
| **KY DMS** | The new standardized prior authorization form is great. If there could be a place for facility and "other" information to be included that would be very helpful. | Patti Sacra - U of Physician |
| **RESPONSE:** | | |
| Panelists thanked Patti for this comment/suggestion | | |

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| **WellCare** | Claims for allergy immunotherapy patients who receive dual shots, a shot in each arm, are rejected because the practice can only bill 1 vial per day. If they bill for both arms the entire claim is denied. | Theresa McCoy, Kentuckiana Allergy |
| **RESPONSE:** | | |
| (Dr. Shaps) This should have changed to 10 units some time ago. Dr. Shaps asked Theresa to see him after the program and he will provide his contact information. | | |
| **KY DMS** | Their providers must apply for a Medicaid Physician Provider ID Number then wait to apply for a separate Dental Provider ID Number. They cannot apply for these two ID Numbers at the same time. With 90 to 120 day waiting periods, this process slows things down drastically for the oral surgeons to be able to provide services to members. Could the process be changed so they can apply for them at the same time, or just have one number for both as the State of Indiana allows? | Teri Trail, University of Louisville School of Dentistry |
| **RESPONSE:** | | |
| Lee does not have all the details for Provider Enrollment but she will find out and respond back to Stephanie Woods at GLMS. October 2017: Medicaid is transitioning to a new system and we are hopeful this will resolve many problems in provider enrollment and re-vailidation. | | |