AETNA BETTER HEALTH Roundtable Questions Submitted	
Aetna Better Health Question 1	Aetna Better Health issued a large refund request on 2/27/18 stating there was an update to the contract that caused a decrease in payment. I have called Aetna Better Health three times, sent two written letters and three emails to our Provider Rep with delivery and read options; emails were read but no response. How can our contract or fee schedule be amended without any notice or response from Finance Dept either? (*Theresa McCoy, Kentuckiana Allergy PSC*)
RESPONSE:	
4/25/18 Response from ABH: Aetna Better Health conducted internal audits that resulted in the update of several codes (internal fee schedule) within the system. The updates were made, claims were reprocessed. This particular group resulted in overpayments, the letter received was notification of the overpayment and request for payment. Two of our Network Consultants met via telephone to discuss the issue. There is a follow up phone call scheduled for later this week. **Further info from 4/26/18 Roundtable:** These were changes to the KY Medicaid Fee Schedule. Aetna Better Health is working on making these letters more specific to provider further information to providers.	
Aetna Better Health Question 2	*Sent to all MCOS* - We have a high number of "No-Shows" from our Medicaid patients. This is costing us large amounts of money. We need more accountability from patients being responsible to make appointments. *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/25/18 Response from ABH: Aetna Better Health recognizes many of the challenges that providers face with the Medicaid population. We have many resources in place to assist members with overcoming any barriers they are experiencing. Providers can contact our Case Management Department at 1-888-470-0550. **Further info form 4/26/18:** Aetna Better Health Case Management works with members to identify and overcome challenges causing these no-shows. Providers may also refer members to the Case Management Deparment.	
Aetna Better Health Question 3	*Sent to all MCOS* - Prior auths: We spend a large amount of time doing and appealing prior authorization requests. Can we just get a blanket approval for our practice? *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/25/18 Response from ABH: Aetna Better Health again recognizes the administrative burden that tasks such as these place on the providers. We have set up many methods to try to assist with decreasing the time spent on administrative tasks. Prior authorizations can be submitted online via the secure Provider Portal, you can speak directly to the PA department via 1-888-604-6106 (BH) 1-888-725-4969 (Med) or the request can be faxed in via 1-855-301-1564 (BH) or 1-855-454-5579 (Med).	

Aetna Better Health Question 4	EKG Interpretations incorrectly denying in Emergency Department. Denial Codes, CO-97 Bundled, N19 Incidental to Primary, N390 Cannot be billed separately. (Claim reference number provided to reps prior to roundtable) *(Carolyn Johnson or Rita Rose, Southern Emergency Medical Specialists)*
RESPONSE:	
4/26/18 Roundtable: Pierre - Aetna Better Health will need to look further into the specifics of this issue at the edits and coding logic for the denials and will follow up with the practice.	
Aetna Better Health Question 5	Approximately 77 claims have denied for no precert. When this issue started in 2016, our rep was Philip Kemper who is no longer with Aetna Better Health. Philip told me the problem was with the logic for the "invisible provider". I took that to mean an issue with their system that did not recognize our group as hospital-based, causing the denials. He said once the logic was fixed, they would open a project to have all of our denied claims reprocessed. Cecilia O'Quinn Spears was also involved at that time. I gave her claims examples and she was able to have 15 of 20 claims re-processed in Dec 2017. She let me know she is no longer involved so I am working with another group at Aetna Better Health trying to get denied claims paid and the denials to stop. On 3/13/18, I was told a project is in process and should hear something in a couple of weeks. Still waiting for this to be corrected. (Claim numbers have been sent to provider reps) (*Mary Langdon, X-Ray Associates of Louisville)*
RESPONSE:	
4/25/18 Response from ABH: Our Network Consultants have been in contact with this provider to address the outstanding claims. 20 of the 77 claims were sent back to ensure the logic was corrected and paying correctly today. The result confirmed the system is set up correctly and paying. All 20 claims were reprocessed and paid. The new claim numbers were forwarded to the provider. The remaining claim will be submitted for reprocessing.	
Aetna Better Health Question 6	CPT 77052-26 was billed with a Mammogram and denied for no qualifying procedure on approx. 9 claims from 2016. The Mammogram (G0202-26) that was billed with CPT 77052-26 IS the Qualifying Procedure and it was paid. Information on this was given to Abby Wilson on 9/15/17. Abby no longer responding so on 1/19/18 I sent an email to Cecilia O'Quinn Spears and still no reply. *(Mary Langdon, X-Ray Associates of Louisville)*
RESPONSE:	
4/25/18 Response from ABH: Our Network Consultants have been in contact with this provider to address the outstanding claims. The original claim denied the add-on code of 77052 because the system did not recognize the presence of primary code G0202. These have since been reprocessed and adjudicated. The new claim information was sent to the provider.	

ANTHEM MEDICAID Roundtable Questions Submitted	
Anthem Medicaid Question 1	*Sent to all MCOS* - We have a high number of "No-Shows" from our Medicaid patients. This is costing us large amounts of money. We need more accountability from patients being responsible to make appointments. (*Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/24/18 Response: We understand this can be a challenge with the Medicaid population due to a number of issues, such as lack of transportation or childcare. We have resources available to help engage these members and assist with overcoming barriers to making scheduled appointments. Please contact our Case Management team by contacting or referring the member to call 1-855-661-2028. **4/26/18 Further info from Roundtable**: Ken Goves noted that Anthem's Case Management may be able to assist members that are experiencing issues that cause them to miss appointments. Providers can help identify these members by referring them to Case Management.	
Anthem Medicaid Question 2	*Sent to all MCOS* - Prior auths: We spend a large amount of time doing and appealing prior authorization requests. Can we just get a blanket approval for our practice? *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/24/18 Response: Anthem's utilization management program is in place to support utilization of the most appropriate medical and behavioral health care in the right place at the right time for our members. Anthem has several methods in place to request a prior authorization: (1) Online via the Interactive Care Reviewer in Availity, (2) Call Anthem at 1-855-661-2028, or (3) Send a fax to 1-800-964-3627. **Further info from Roundtable:** Ken Groves - if we see a lot of utilization on a particular service, Anthem will review that service to consider if prior authorization is still necessary.	
Anthem Medicaid Question 3	Anthem Medicaid is no longer paying Xrays done with an E/M in the Emergency Dept. These were paid in the past and are payable per KY Medicaid. If this is an issue caused by a new edit being implemented, what is the ETA on correction of these claims that are denying in error? (Claim reference number provided to reps prior to roundtable) *(Carolyn Johnson, Southern Emergency Medical Specialists)*
RESPONSE:	
[Response Prior to Roundtable: On 4/3/18, PR Rep Jennifer Smith responded to Carolyn stating she reviewed the claims examples provided and was unable to determine why the claims didn't pay out. Jennifer submitted an internal inquiry to have our Claims Operations team investigate a little further. The PR inquiry process is separate from an appeal as it allows our operations team to investigate issues without exhausting the providers appeal rights] 4/24/18 Updated Response from Anthem: Claims denied, not covered for provider specialty. The denied claims were billed by the emergency physician as the X-rays had to be read by the ER Physician in an ER setting due to no radiologist being on staff at time of interpretation. This is done to administer a plan of care at time of service. The billed procedures, 71010 and 73610, were reported with modifier 26 (Professional component), were denied because the interpretation of the imaging service was billed in a hospital setting by a specialty that is not typically responsible for providing radiological interpretations for the hospital. Reporting of an x-ray procedure requires permanently recorded images. In addition, the professional component (interpretation) of radiological procedures should only be reported by the provider who provided the formal written interpretation and report. Documentation would be required for further review. **Further info from 4/26/18 Roundtable:** Ken Groves - If there is not an eligible professional available to read xrays in the emergency setting, then medical records should be sent with the claim to explain this unique scenario. Anthem reps will continue to work with the practice to help with this issue.	

HUMANA CARESOURCE Roundtable Questions Submitted	
Humana CareSource Question 1	*Sent to all MCOS* - We have a high number of "No-Shows" from our Medicaid patients. This is costing us large amounts of money. We need more accountability from patients being responsible to make appointments. *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/24/18 Response from CareSource: Providers have the right to dismiss members who consistently no show for their appointments. In order to dismiss a member a provider must send the member a certified letter in the mail as well as send a copy of the letter to the Humana CareSource, the provider also has to be available to see the member for urgent matters for 30 days after the sending the certified letter. **Further from 4/26/18 Roundtable:** Providers are encouraged to refer members to case management if a need is identified. If the patient is dismissed from the practice, Humana Caresource asks that a notification also be sent to them when their member is no longer with the practice.	
Humana CareSource Question 2	*Sent to all MCOS* - Prior auths: We spend a large amount of time doing and appealing prior authorization requests. Can we just get a blanket approval for our practice? (*Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/24/18 Response from CareSource: Humana CareSource reviews all service requests for Medicaid members under the age of 21 for medical necessity. Prior authorization is not solely based on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. Unfortunately, Humana CareSource is unable to provide a blanket approval as each prior authorization request is unique and has different requirements for approval. **Further info from 4/26/18 Roundtable:** Currently the process is not changing and providers are encouraged to utilize the provider portal for pre auths as it is much faster. Each prior auth request is unique so a blanket approval would not be possible. Providers may reach out to Caresource if they are experiencing issues with consistent prior auth requests for a specific service and would like to discuss.	

PASSPORT HEALTH PLAN Roundtable Questions Submitted	
Passport Health Plan Question 1	Since Passport implemented the new system we haven't been paid correctly for bilateral procedures. I reached out to Dell Fraze a few times regarding our bilateral myringotomy & tube insertion (69436-50) but haven't received a response since the first email.They are paying the bilaterals as unilateral. I called (11/30) and had one of them reprocessed but they have not paid it yet. I reached out to Dell on 1/19 and provided her with two examples per her request. I haven't heard anything from her since then despite requesting the status. *(Michelle Bowling, Louisville Family ENT)*
RESPONSE:	
[Response from Dell prior to roundtable - The issue with the 50 modifier not recognizing the bilateral service is in review as this has been reported by numerous providers. I also had one provider tell me that rather than using the 50 modifier our claims department advised they should use RT & LT, this has also been sent for review. I have an alert set up so that any update to the problem report will be sent to me. I will provide updates as I receive them. I apologize for the delay we are experiencing with updates however please know that issues are being reviewed by the appropriate departments.] 4/24/18 Response from Passport**:** The issue with the 50 modifier not recognizing the bilateral service is in review. Provider representative will keep provider updated on progress. Once issue is identified, claims will be reprocessed.	
Passport Health Plan Question 2	Passport is no longer requiring referral forms. How are referrals tracked and verified going forward? *(GLMS)*
RESPONSE:	
4/24/18 Response from Passport: Effective immediately, Passport will no longer require referral forms of any type. Passport will instead validate your referrals through claims submissions. For auditing purposes, documentation of your practice's preferred referral method will need to be on file in your office. Specialists need to complete Boxes 17 and 17b of the CMS-1500 claims form to identify your referral. Please see the Claims Form Instructions for details on what to include in Box 17 including appropriate qualifiers, such as DN (referring). See online e-news for detailed information and claim form example. **Further info from 4/26/18 Roundtable:** Providers may use their own forms or continue to use Passport's form for referrals and keep them in the member's medical record. Referrals are still required, however, forms are no longer required to be submitted.	
Passport Health Plan Question 3	Passport still has not paid any of our mammogram claims filed during the first six months of 2017. After repeated emails to Passport rep and a special project spreadsheet, the claims are still not paid. (*Melody Kappesser, University of Louisville Physicians Radiologic Associates)*
RESPONSE:	
4/24/18 Response from Passport: Claims are now paying correctly. Claims have been sent to Passport claims department for re-processing.	

Passport Health Plan Question 4	Can you please provide a status update on Passport correcting crossover claims where they are secondary to any insurance other than Medicare? Since Passport's system changes in 2017, secondary claims have had to be dropped to paper and mailed versus electronic crossover submission. Passport has just recently corrected Medicare crossover issues. Efficiency in today's electronic age is definitely not being utilized with this new system. Practice has been working with Passport Rep, Amber Henderson, and most recently was informed that they are working to add the electronic secondary filing with the new system. Is there an ETA on when this will be configured? *(Carolyn Johnson or Rita Rose, Southern Emergency Medical Specialists)*
RESPONSE:	
4/24/18 Response from Passport: Passport can accept secondary claims electronically, but many are being denied for EOB due to a system issue. The issue is being actively worked with an expected completion date of **May 30.**	
Passport Health Plan Question 5	Passport is inappropriately denying X-rays since Oct. 2017 due to edit issues with the new system. (N95- Provider/Specialty may not bill and N96- Non Covered Charge). Practice has also been working with Passport Rep, Amber Henderson, on this issue and as of April 2 a fix was supposedly put in place but the practice is still receiving denials. We would like an update and an ETA on resolution to this issue. (Rita Rose, Southern Emergency Medical Specialists)
RESPONSE:	
4/24/18 Response from Passport: This is a global issue and is in configuration. Claims will be reprocessed once configuration is complete. Specific information for Southern Emergency denials emailed to provider on 4/24/18.	
Passport Health Plan Question 6	*Sent to all MCOS* - We have a high number of "No-Shows" from our Medicaid patients. This is costing us large amounts of money. We need more accountability from patients being responsible to make appointments. (*Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/24/18 Response from Passport: We encourage our Behavioral Health Provider Partners to reach out to our members to remind them of booked appointments. Currently under DMS reguiations, Medicaid members cannot be charged for no show appointments. **Further from 4/26/18 Roundtable**: Refer members to Case Management or other Passport Health Plan representative.	
Passport Health Plan Question 7	*Sent to all MCOS* - Prior auths: We spend a large amount of time doing and appealing prior authorization requests. Can we just get a blanket approval for our practice? *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/24/18 Response from Passport: Prior authorizations are required for certain services to ensure medical necessity criteria are being met. Passport will continue to use prior authorization processes for our providers, however if you have any questions around a prior authorization denial please contact our Behavioral Health Access Line at 855-834-5651.	

Passport Health Plan Question 8	Passport is overpaying claims when they are the secondary payer and they have the primary EOB. Passport is aware of this issue and trying to resolve but we would like to have an ETA. Approx 40 claims. *(Mary Langdon, X-Ray Associates of Louisville)*
RESPONSE:	
4/24/18 Response from Passport: This issue is currently in configuration. Once configuration is complete, claims will be reprocessed. Expected completion date for correction is **May 30.**	
Passport Health Plan Question 9	New CPT codes as of 1/1/18 are denying for no assigned fee. This issue is related to the loading of the KY Medicaid fee schedule for 2018. Over 100 claims denied. When will this be corrected? (Claim numbers, Reference numbers and CPT codes sent to reps prior to roundtable) *(Mary Langdon, X-Ray Associates of Louisville)*
RESPONSE:	
4/24/18 Response from Passport: Configuration has been completed for this issue. Claims have been sent to our claims department for re-processing.	
Passport Health Plan Question 10	Passport Medicaid is returning ALL claims that are secondary to PASSPORT ADVANTAGE (Adjudication on payment date on Line 1 is not present). Claims are not able to go electronically and now we have to spend double postage to send the exact same thing twice! (*Rita Rose, Southern Emergency Medical Specialists)*
RESPONSE:	
4/24/18 Response from Passport: See response for question 4.	
Passport Health Plan Question 11	Passport rejecting 76 Modifier on claims. Per Customer Service Supervisor, Ann B., there is no ETA on when this issue will be fixed but she assumes it is an edit issue. *(Rita Rose, Southern Emergency Medical Specialists)*
RESPONSE:	
4/24/18 Response from Passport: This is as global issue. This issue is currently in configuration, and claims will be reprocessed once configuration is complete.	
Passport Health Plan Question 12	Multiple claims where Ocular injection denied for "NOC Quantity". (Claims examples sent to Passport prior to roundtable) *(Kathy Plummer, Kentucky Eye Surgery Associates)*
RESPONSE:	
4/24/18 Response from Passport: This is as global issue. This issue is currently in configuration, and claims will be reprocessed once configuration is complete. **Further from 4/26/18 Roundtable**: Additional complaints have been received and this issue is being escalated.	

WELLCARE Roundtable Questions Submitted	
Wellcare of KY Question 1	Our billing office notified me in August of 2017 of an issue with claim rejections with Wellcare of KY. The reason on the rejections is "701-Unable to obtain a unique Medicaid ID for Billing Provider NPI, or Zip-5 on the State Roster". We tried to get some clarification about exactly what did not match, but we got the same response each time ... "701-Unable to obtain a unique Medicaid ID for Billing Provider NPI, or Zip-5 on the State Roster". Finally, we were told that we needed to "reach out to the state of KY and ask them about getting an out of state provider registered on the Roster since you are seeing a KY Medicaid member". We are not an out of state provider, but we use an out of state billing agency. We called KY Medicaid and verified our information numerous times. We asked about who updates the KY Roster. Apparently, no one knows. KY Medicaid staff told us they don't have access to update or even view the roster (nor do we or our billing agency). We have since contacted our Wellcare of KY rep, Tasia Spencer, and also the representative who we were told handles Wellcare of KY for KY Medicaid, Lisa G. Thompson. After all these people looked over our informaiton, a decision was made to update our correspondance address with KY Medicaid. I mailed the appropriate forms on 10/26/17 and they were received by KY Medicaid on 10/31/17. Those updates were not finalized until 3/18/18 (almost 5 months later). I just found out today, 3/22/18 that our claims are still rejecting for the same reason. As this point, I have been told that our billing office estimates our outstanding claims with Wellcare to be in excess of $350,000. (*This issue is listed on both Wellcare and DMS spreadsheet) (Phyllis Patterson, Diagnostic X-Ray Physicians, PSC)*
RESPONSE:	
4/26/18 Roundtable: Lisa Lawson- This individual issue has been researched is being addressed with the practice. There were two Medicaid ID numbers involved and the system could not identify the appriate number.	
Wellcare of KY Question 2	Wellcare Provided Authorization For Surgery stating service met their determination criteria. The claim and subsequent level II dispute, were denied with the reason "the service is a questionable service" per their policy. When verifying benefits prior to surgery, the Wellcare rep did not indicate the procedure was not covered. We have been working toward a successful resolution of this claim for several months. Surgery was 9/11/17. *(Melanie Robinson, John W Derr, Jr, MD)*
RESPONSE:	
[Response from Lisa Lawson prior to roundtable on 3/20/18 - I have asked the claims team to review the denial and provide me with their response. As soon as I receive additional information, I will let you know.] Further info provided by Lisa Lawson 4/25/18: Claim # 737379893; Authorization # 122481848 was approved and claim adjusted for payment in the amount of $1,130.81. **Further from 4/26/18 Roundtable:** Payment should have been received by the provider at this point as this was adjusted about 30 days ago.	

Wellcare of KY Question 3	Since Wellcare made changes in their claims editing a few months ago, they do not recognize NPI/taxonomy numbers although verified with provider representative and KY Medicaid that our information is correct.The only way we can get paid is by paper claims. Availity has also attempted to work with Wellcare but Wellcare has not responded for quite some time back to us. I finally decided to send paper claims and they are paying but again, their recent edit has caused many headaches and non-payments and we cannot fix what is not broken on our end. This continues to remain the issue so we are filing paper claims to get reimbursed. *(Theresa McCoy, Kentuckiana Allergy)*
RESPONSE:	
4/25/18 Response from Lisa Lawson: WellCare previously requested examples of claims denials from Kentuckiana Allergy to review in order to determine the issue. No denials were received. If provider can email claims examples, WellCare will research the cause. Or, for electronic claims submission issues, provider may reach out directly to EDI-Master@wellcare.com. **Further from 4/26/18 Roundtable**: Lisa contacted the EDI department 4/25/18 and a representative has reached out to Theresa McCoy to address this issue. EDI is reviewing the rejections and once that analysis is complete, the results will be shared with the provider.	
Wellcare of KY Question 4	*Sent to all MCOS* - We have a high number of "No-Shows" from our Medicaid patients. This is costing us large amounts of money. We need more accountability from patients being responsible to make appointments. *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/25/18 Response from Lisa Lawson: WellCare recognizes it can be difficult to manage scheduling appointments with Medicaid members. WellCare offers comprehensive integrated Care Management services to facilitate patient assessment, planning and advocacy in order to improve health outcomes for patients. A Community Assistance Line is also available for WellCare members to call for a referral to a social service such as food assistance, financial assistance, utility assistance, transportation, support groups, homeless shelters, and more.	
Wellcare of KY Question 5	*Sent to all MCOS* - Prior auths: We spend a large amount of time doing and appealing prior authorization requests. Can we just get a blanket approval for our practice? *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/25/18 Response from Lisa Lawson: On August 5, 2017, WellCare reduced the amount of services/procedures requiring prior authorization for its **Medicare** line of business. In February 2018, **similar changes were made to our Medicaid line of business** to further simplify and streamline our authorization rules and requirements. These updates are designed to help ease your day-to-day interactions with WellCare while allowing us to continue to exercise responsible stewardship over the government funded health care programs we administer. We reduced CPT codes that require outpatient authorizations by over 60% and outpatient authorization requirements were applied across all places of service. **Further from 4/26/18 Roundtable:** Lisa Lawson - Wellcare has a new provider portal that makes online preauth requests much faster in addition to the preauth lookup tool online. Feedback from providers on the reduction in the number of preauths has been positive.	

Wellcare of KY Question 6	Several claims denying for no precert. Our group consists of Hospital Based Radiologists and we do not call for precerts for any insurance as this is the responsibility of the ordering provider or facility. (Claim numbers were provided to reps prior to roundtable.) *(Mary Langdon, X-Ray Associates of Louisville)*

RESPONSE:

4/25/18 Response from Lisa Lawson: Prior authorization is required for elective or non-emergency services as designated by WellCare. Guidelines for prior authorization requirements by service type may be found on the Quick Reference Guide on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid. Providers can also use the searchable Authorization Lookup Tool at www.wellcare.com/Kentucky/Providers/Medicaid. The ordering, referring or attending physician is responsible for obtaining prior authorization from WellCare and for providing the prior authorization number to each WellCare provider associated with the case; i.e., assistant physician and hospital, etc. Requests for prior authorization should be submitted at least 10 business days prior to the planned procedure. Once a procedure is approved, the approval is valid for 90 days from the date of issuance. **Further from 4/26/18 Roundtable:** This information may also be found in the Wellcare provider manual.

Kentucky Department of Medicaid Services Roundtable Questions Submitted	
DMS Question 1	What is the estimated timeframe for KY Medicaid provider enrollment to be available via provider portal instead of having to mail enrollment applications and forms? (*GLMS)*
RESPONSE:	
4/25/18 Response from Lee: Currently the target is Summer 2018 **Further from 4/26 Roundtable:** the date for this has been pushed back several times but right now it is still the summer of 2018. The new law recently passed related to Medicaid credentialing/provider enrollment may add additional delays to this implementation. Pilot projects are currently being utilized by some hospital systems to test the portal and help work through some of the issues. More information to be announced as it becomes available. Documents will be able to be uploaded to the portal and status of the documents	
DMS Question 2	Where should providers go to find information on the changes to Medicaid (expansion),"KY HEALTH", specifically how their patients may be affected by the changes? *(GLMS)*
4/25/18 Response from Lee: KENTUCKYHEALTH.KY.GOV. **Further from 4/26/18 Roundtable**: Resources available at KentuckyHealth.KY.Gov. Provider Forums taking place now, the next one is scheduled for May 3 in Louisville. Registration is required and CJ will send information about the forum to Stephanie (GLMS) to share with attendees.	
DMS Question 3	*Sent to all MCOS* - We have a high number of "No-Shows" from our Medicaid patients. This is costing us large amounts of money. We need more accountability from patients being responsible to make appointments. *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/26/18 Roundtable: There are less than 200 people that work in the state Medicaid agency. As previously stated, Medicaid members may not be charged "no-show" fees and Medicaid will not pay for services that are not covered by Medicaid.They are, however, moving toward gathering more data and will take the question back about collecting hard data about no-shows among Medicaid populations. This is a great example of needing more data in order to quantify some of the no show reasons.	
DMS Question 4	*Sent to all MCOS* - Prior auths: We spend a large amount of time doing and appealing prior authorization requests. Can we just get a blanket approval for our practice? *(Kenneth Cordle, Sullivan Psychiatric Group)*
RESPONSE:	
4/25/18 Response from Lee: Sorry that would defeat the purpose of a prior authorization.	

DMS Question 5	Inpatient Medicaid coverage for incarcerated patients - Practice needs coverage for 7 inmates for dates of service June 2017, July 2017, Sept 2017, Nov 2017, Dec 2017. [Additional Details Added: It has been our understanding that Correct Care is responsible for obtaining coverage for inpatient inmates. I just called Correct Care and was told it is the responsibility of the health services division at the Department of Corrections but she could not give me a name or contact number. Also, I just rebilled a few accounts. They show the inmate eligible on the date of service, coverage does not show suspended for incarceration and program code is X3. As long as they do not show suspended, I may be able to get my claims paid. FYI…inpatient claims always go to KY Medicaid. Outpatient and ER go to Anthem as of 8/1/17. Prior to that, they went to Humana) *(Mary Langdon, X-Ray Associates of Louisville)*
RESPONSE:	
4/26/18 Roundtable: Lee will work with Mary Langdon after the roundtable. A lot of things in process for incarcerated individuals and continue to work through issues with the process. If the issue is with the MCO recouping payment on one of these claims, send them to CJ.Jones@ky.gov.	
DMS Question 6	(This issue is on both Wellcare and DMS spreadsheet) Our billing office notified me in August of 2017 of an issue with claim rejections with Wellcare of KY. The reason on the rejections is •701-Unable to obtain a unique Medicaid ID for Billing Provider NPI, or Zip-5 on the State Roster". We tried to get some clarification about exactly what did not match, but we got the same response each time ... "701-Unable to obtain a unique Medicaid ID for Billing Provider NPI, or Zip-5 on the State Roster". Finally, we were told that we needed to "reach out to the state of KY and ask them about getting an out of state provider registered on the Roster since you are seeing a KY Medicaid member". We are not an out of state provider, but we use an out of state billing agency. We called KY Medicaid and verified our information numerous times. We asked about who updates the KY Roster. Apparently, no one knows. KY Medicaid staff told us they don't have access to update or even view the roster (nor do we or our billing agency). We have since contacted our Wellcare of KY rep, Tasia Spencer, and also the representative who we were told handles Wellcare of KY for KY Medicaid, Lisa G. Thompson. After all these people looked over our informaiton, a decision was made to update our correspondance address with KY Medicaid. I mailed the appropriate forms on 10/26/17 and they were received by KY Medicaid on 10/31/17. Those updates were not finalized until 3/18/18 (almost 5 months later). I just found out today, 3/22/18 that our claims are still rejecting for the same reason. As this point, I have been told that our billing office estimates our outstanding claims with Wellcare to be in excess of $350,000. *(Phyllis Patterson, Diagnostic X-ray Physicians, PSC)*
RESPONSE:	
4/25/18 Response from Lee: I will need to gather more information before I can respond to this question. **4/26/18 Roundtable**: Lee will speak to this individual following the roundtable.	

DMS Question 7	(Medicaid Fee Schedule) Payment for CPT 67900 is just not fair to any physician. Dr. Arterberry has also said he would be more then happy to also speak with someone to try to get this adjusted. Below is a summary of what the code pays and what it involves. On CPT 67900 brow ptosis repair - the unilateral payment is $239.47 so bilateral is $359.20. After Dr. Arterberry found out this Medicaid fee for this CPT he does not want to do these for that rate. It is a 2 hour procedure with 2 layer closure (nearly 150 sutures total). Taking into account the time to pre cert, the time it takes to properly mark the incision site prior to the surgery, the surgery itself and also the 3 month post op period, Dr. Arterberry is losing money and feels he is giving this one away. Is there anyway to negotiate a price for the brow ptosis repair with KY Medicaid? *(Terri Arnold, Dr. Joe Arterberry)*
RESPONSE:	
4/26/18 Roundtable: Medicaid has not increased their fees since around 2010 because of budget constraints. Lee spoke to the fee schedule specialist and while they are paying less than surrounding states and less than some of the MCOS, it will likely not be increased depending on the overal fiscal impact.	

2018 GLMS Medicaid Roundtable

Questions/Discussion During Roundtable

Questions/Discussions During Roundtable	
No-Shows	Clarification on notifying the Mediciad and/or the MCO when a member is dismissed from the practice
RESPONSE:	
Lee Guice confirmed that this is not a Medicaid requirement. MCO representatives noted that while this is not REQUIRED, they encourage providers to share this information with them.	
No-Shows	Frances Burton asked why Medicaid members can't be charged no-show fees.
RESPONSE:	
Lee Guice responded that Federal Law prohibits billing Medicaid members for not showing up	
No-Shows	Dr. Goldberg asked if any of the MCOS or DMS have collected hard data on no-shows and the reasons why members don't make their appointments. In a general sense we have an idea of many of the social issues behind no-shows but until we have hard data, we can't accurately address the problem. No-shows are annoying and cost the provider time but they are very costly to Medicaid when the patient ends up with unnecessary complications that could have been addressed earlier had they not missed their appointment.
RESPONSE:	
Aetna Better Health, Pierre - Case Management Departments may have some information on this but not a complete picture. There are opportunities to improve in this area if the data were able to be captured. **Passport Health Plan,** Dr. Steve Houghland - Unfortunately, the payer only knows what is reported to them. If the member is engaged in case management then the informaiton is collected but more commonly the MCO is not informed that the member no-showed for an appointment. For this reason, feedback from the provider is helpful, especially when there is a trend as with those with a history of no-shows. Passport has limited hisorical inofrmaiton going back a couple years and the mose common "reasons" given were issues with transportation, child care or just forgot appointment. The more the MCO can engage with providers, the more information can be shared to address this. In response to a question asked about whether a MIPS measure would help track this if it were built in with a code, Dr. Houghland responded, "yes, if administrative data was provided that would be helpful. Still, systems would need to be configured to allow the code to be received by the MCO and ultimately received by DMS so theses issues would have to be worked through and would be worth looking into." **Follow-up Request :** Mark Prussian asked that each MCO work on initiatives to address no-shows and the current lack of collected data and we can discuss the progress made on this at the next Medicaid Roundtable (Spring, 2019).	
Passport Referrals	For return visits, is another referral required by Passport?

2018 GLMS Medicaid Roundtable

Questions/Discussion During Roundtable

RESPONSE:	
Referral requirements have not changed. The PCP referral is good for 1 year and documentation can be added to medical record.	
Passport Referrals	Problem with PCP offices not wanting to give referrals because they think it is no longer required by Passport.
RESPONSE:	
Contact Passport representatives so they can reach out to the PCP to provide education and clarification on the changes. Referrals are still required.	
Ordering, Referring, Prescribing Providers	Denials from Passport because referring physician is not a Medicaid provider. Can we not receive referrals from non-Medicaid providers? Also, even if the physician is a Medicaid provider claims are denying if the referral is done by a mid-level practitioner that is not a Medicaid provider.
RESPONSE:	
Passport - New state guideline that the Ordering, Referring or Prescribing providers must be in-network with Medicaid. **DMS -** As long as the rendering provider is a Medicaid provider then claim is payable, however, if an out of network referring provider is listed on the claim, it will be denied. Providers can check the Medicaid provider portal (https://prdweb.chfs.ky.gov/ProviderDirectory/PDSearch.aspx) to see if referring provider is active with Medicaid. The MCOs also have provider portals where this information should be able to be found.	
Passport System issues	Will all issues that are a result of the Oct, 2017 Passport Health Plan system conversion be resolved by the end of May, 2018?
RESPONSE:	
Passport - We appreciate everyone's patience through this system conversion, the first system change in 20 years. Not all of the issues are expected to be complete by May 30 but if there are concerns that have not yet been addressed, please contact your Passport representative.	
Passport System issues	Does Passport anticipate similar issues with their upcoming changes to the Passport Medicare system?
RESPONSE:	
The Passport Medicare system is a completely different system and further information is not yet available on these changes. An enews will be released when more information is available. GLMS asked that they provide as much information in advance as possible including communicating known issues as they arise so providers can be aware of what to expect and that the issues are being addressed.	

2018 GLMS Medicaid Roundtable

Questions/Discussion During Roundtable

Secondary Claims	Issues with claims for patients with Medicare primary and MCO secondary. MCO is denying the claim because a modifier may not be there that is not required for the Medicare claim. The MCOs have different billing requirements. Usually this is when billing a 99213.
RESPONSE:	
DMS, CJ - Any issue that is not being resolved by the MCO, go to http://chfs.ky.gov/NR/rdonlyres/F1574AAD-06BF-473B-94E7-26B3E5C742D8/0/DMSFillableComplaintFormUpdate2017.pdf and complete the MCO Complaint Form. DMS is addressing compliance issues with the MCOs especially on issues that have gone on for 6 months with no resolution. Provider should not wait this long, you can also copy cj.jones@ky.gov but she will not address issues until the MCO Complaint Form has been submitted.	
CLIA certifications	Medicaid CLIA certifications have been sent to DMS but claims are being denied. Are they backlogged in processing new CLIA certifications?
RESPONSE:	
CJ - KY Medicaid is backlogged on most everything where provider enrollment is concerned. Call provider enrollment to check the status of processing.	
Bilateral/ Unilateral procedures	When a bilateral procedure is performed, does each MCO require a 50 modifier on one line, or a 50 modifier on the 2nd line, or 2 lines - one with a RT for right and the other with a LT for left? For a unilateral procedure do they need to know which side the procedure was performed on? This could apply to many procedures.
RESPONSE:	
Stephanie (GLMS) to ask each MCO about their billing guidelines for Mod 50, Left / Right. **4/30/18 Sent to all MCOs for response.**	
ABH	**4/30/18:** BILATERAL PROCEDURES - Bilateral procedures are defined as those performed on two (2) sides of the same surgical area. Bilateral procedures should be submitted with one unit and include a 50 modifier. Claims for bilateral procedures noted with a 50 modifier and containing more than one unit will be split onto two (2) lines for correct processing. This information is found on page 105 of the provider manual. I have included the link below. https://www.aetnabetterhealth.com/kentucky/assets/pdf/providers/manual/provider-manual-ky.pdf

Questions/Discussion During Roundtable

Anthem Medicaid	**Multiple and Bilateral Surgery: Professional and Facility Reimbursement** https://mediproviders.anthem.com/Documents/KYKY_CAID_RP_MultipleandBilateralSurgery.pdf Bilateral Surgery - Professional provider and facility claims with applicable surgical procedures must be billed with Modifier 50 to denote a bilateral procedure. It is inappropriate to use Modifier LT or RT to identify bilateral procedures. Reimbursement is 150% of the fee schedule or contracted/negotiated rate of the procedure. For procedure codes containing "bilateral" or "unilateral or bilateral" in their description, no modifier is used, and reimbursement is based on 100% of the fee schedule or contracted/negotiated rate for the procedure. Claims with applicable surgical procedures billed without the correct modifier to denote a multiple or bilateral procedure may be denied. In the instance when more than one bilateral procedure or multiple and bilateral procedures are performed during the same operative session, multiple procedure reductions apply.
Humana Caresource	
Passport	
Wellcare	
Referral Requirements	Clarification on which MCOs require referrals. Especially with Humana Caresource, some denials for referring provider not being a Medicaid provider
RESPONSE:	
Humana Caresource DOES NOT require referrals, however, if a referring provider is listed on a claim then it will deny if that provider is not active with KY Medicaid. For Humana Caresource, the claim will pay if no referring provider is listed on the claim.	
Medicaid Coverage	Viscosupplementation (3-5 injections) vs. total knee replacement. Medicaid and the MCOs have different coverage policies on this. This forces patients to opt for total knee replacement if they cannot get coverage for Viscosupplementation with their MCO. Can we request this to be covered the same way across all MCOs?
RESPONSE:	

2018 GLMS Medicaid Roundtable

Questions/Discussion During Roundtable

Lee - we will take your question back and look at the Medicaid policy. It is likely that there is a prior authorization requirement resulting from different approval policies with the different MCOs. **FOLLOW-UP:**
FYI: Passport Health Plan will be hosting upcoming Provider Workshops on KY Health.
FYI: Wellcare will be having a Provider Summit on May 31 in Louisville.