2019 GLMS MEDICAID ROUNDTABLE ISSUES

AETNA BETTER HEALTH Roundtable Questions Submitted	
Aetna Better Health Question 1	This issue remains unresolved from the 2018 Medicaid Roundtable: CPT 77052-26 billed with a Mammogram and denied for no qualifying procedure. The Mammogram (G0202-26) that was billed with CPT 77052-26 IS the Qualifying Procedure and it was paid. rovider still awaiting payments from Aetna Better Health on 21 unpaid claims that go back as far as 2016. The last payment on a claim from the list was 11/7/18. Multiple conversations and ABH provider rep changes. As of 3/21/19 ABH says they are awaiting approval to pay these claims. *(Mary Langdon, X-Ray Associates of Louisville)*
Response:	**4/9/19 Response from ABH**: ABHKY has reviewed and reprocessed all claims that are payable. The 21 claims outstanding were denied correctly. The claims were denied for no prior authorization obtained. X-Ray Associates is NON Participating with ABHKY; the services were performed at place of service 22 and therefore would require a prior authorization. ABHKY would be willing to speak with the provider about a contractual agreement. **Further info from 4/10/19 Roundtable:** I (Joann Rose) have been working with Mary Langdon off and on probably since this time last year. So, we've reprocessed everything that we can. Ones that were outstanding required a prior authorization because she was out of network and we are not able to process those at this time. I have sent her a breakdown of each claim and explained why each could not be processed.
Aetna Better Health Question 2	We have several claims that are not getting paid and we have exhausted all means of submitting everything that was asked. I ended up copying entire medical charts and sending the records via certified mail and still no payment. Claim number(s) 17006218, 16889001, 16702597, and so many more. We submit code 95165, (allergy immunology serum) which we make in our office. We have patients that see Dr. Kuhn in the office and then we make the allergy vials and mail them to the patients primary care doctors office so that the patient can receive the allergy injections near their home residence. Every claim that we have submitted returns as code 226, which is: Information was Insufficient/Incomplete and then also N705 Invalid documentation. We have claims that are almost over 1 year old now. We have submitted every piece of patient documentation to Aetna Better Health. I decided to start sending the ENTIRE patient medical records via "Certified Mail" now. Aetna Better Health has still denied claims and has stated that they have received the information that they need to pay the claims. I sent Mr. Victoravich (Aetna Better Heath's Senior Investigator) an email last week explaining that if our practice does not receive payments on our claims, then we will no longer accept Aetna Better Health insurance any further. The amount of hours and rate of pay for the staff to copy the entire patient medical records, go to the post office, pay for certified mail, and then not receive payment is absurd. (*Jessica H., Dr. Forrest S. Kuhn's office)*
Response:	**4/9/19 Response from ABH:** Aetna (John Victoravich) has been working directly with Jessica the office manager concerning the claims and/or medical records that have been requested. Claims where the medical records were received were reviewed and processed accordingly. The claims mentioned in this request are awaiting the medical records to arrive. Aetna has asked Jessica to kindly provide the mail service utilized, date sent, and any tracking numbers, in an effort for Aetna to conduct an additional search to locate said records. All searches to date for additional medical records have proven negative. Additional emails were received from the practice manager; however, to date we have not received the medical records. At this time Aetna is still waiting on the medical records. **Further info from 4/10/19 Roundtable**: Aetna is still waiting on records from Jessica. GLMS can help facilitate.
Aetna Better Health Question 3	ALL MCO ISSUE: Is an Orthognathic Surgery approval required prior to patients starting Orthodontic treatment (braces) that will later require jaw Orthognathic Surgery. Would like a fee schedule of covered codes Medical and Dental. *(Bridget Lanier, University of Louisville Dental Associates)*
Response:	**4/9/19 Response from ABH:** We have reached out to the provider for additional information on this question.

2019 GLMS MEDICAID ROUNDTABLE ISSUES

ANTHEM MEDICAID Roundtable Questions Submitted	
Anthem Medicaid Question 1	ALL MCO ISSUE: Is an Orthognathic Surgery approval required prior to patients starting Orthodontic treatment (braces) that will later require jaw Orthognathic Surgery. Would like a fee schedule of covered codes Medical and Dental. *(Bridget Lanier, University of Louisville Dental Associates)*
Response:	**4/9/19 Responses from Anthem: a.** Orthognathic surgery does require preauthorization, as well as braces. For deficiency that cannot be corrected by orthodontic services and that may require orthognathic surgery, a prior authorization is required for the orthognathic surgery. **b.** The UM team at DentaQuest reviews a multitude of conditions that would qualify a member for orthodontic surgery for correction, but it is not a requirement to be approved. See separate handout showing KY criteria from the ORM that is used when making a clinical determination for new orthodontic cases.
Anthem Medicaid Question 2	Can you confirm that the following will apply to Anthem KY Medicaid: Beginning with claims processed on or after May 1, 2019, Anthem may deny the E&M service with a Modifier 25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record. *(GLMS)*
Response:	**4/9/19 Responses from Anthem**: **a.** Correct, we have identified that duplicate E&M services are being billed on the same day for a same/similar service. These have been billed by the same provider or providers within the same group and will no longer be allowed starting May 1st. **b.** We follow the same AMA & CMS guidelines for modifier 25. https://mediproviders.anthem.com/Documents/KYKY_CAID_RP_Modifier25SignificantSeparatelyIdentifiableEMServices.pdf **c.** Please reference Modifier 25: https://mediproviders.anthem.com/Documents/KYKY_CAID_evalandmanagementmodifier.pdf **Further info from 4/10/19 Roundtable: Nothing with Modifier 25 is changing.** We are just going to begin taking a closer look at claims that have Modifier 25 on them. You can submit claims and they will be paid according to the AMA, CMS, & CPT coding guidelines. We will just be taking a closer look at this just to make sure that Modifier 25 & Modifier 57 are being appropriately applied and utilized. Now, if you have a claim denied by Anthem you still have the option to dispute the claim. We aren't going to be denying claims or E/M codes just because you're submitting them for a minor or major procedure with these two Modifiers.
Anthem Medicaid Question 3	Can you confirm the following change that was withdrawn in 2018 is currently in place for Anthem Ky Medicaid; Effective April 1, 2019, Anthem does not allow separate reimbursement for E&Ms performed on the same day as a major surgery (90-day global period). Anthem only allows reimbursement for one E&M service per day. *(GLMS)*
Response:	**4/9/19 Responses from Anthem: a.** For the 90-day Global period, please reference the reimbursement policy for modifier 57 at the following link; https://mediproviders.anthem.com/Documents/KYKY_CAID_RP_Modifier57DecisionforSurgery.pdf **b.** Reimbursement policy that covers Modifier 25 and 57 effective 4/1/19. https://mediproviders.anthem.com/Documents/KYKY_CAID_Modifier25ArticleUpdate.pdf **Further info from 4/10/19 Roundtable:** Basically, we don't allow for a separate reimbursement for E/M's performed on the same day as a major surgery.

2019 GLMS MEDICAID ROUNDTABLE ISSUES

HUMANA CARESOURCE Roundtable Questions Submitted	
Humana CareSource Question 1	ALL MCO ISSUE: Is an Orthognathic Surgery approval required prior to patients starting Orthodontic treatment (braces) that will later require jaw Orthognathic Surgery. Would like a fee schedule of covered codes Medical and Dental. *(Bridget Lanier, University of Louisville Dental Associates)*
Response:	**Follow-up from Erin Samuels, after the 4/10/19 Roundtable:** Received the following response from Kentucky State Dental Director, Dr. Jerry Caudill; "Currently, Avesis does not require Orthognathic Surgery approval prior to patients starting Orthodontic treatment (braces) that will later require jaw (Orthognathic) surgery. That being said, it has been discovered some providers are starting skeletal orthodontic cases knowing the parents, care givers, and/or patients have no intention of having the surgery later. This was discussed with Dr. Ken Rich who was the DMS Medicaid Dental Director at the time. His position on this was that it was not appropriate and amounted to treating cosmetics only if the follow-up surgery was not going to be completed. As we all know, Medicaid and the EPSDT program does not cover cosmetic dental care. It is therefore our intention to submit to the MCOs and DMS prior authorization criteria for D8080 regarding a member needing skeletal orthognathic surgery must obtain a consultation and approval for the surgery prior to submitting the prior authorization for braces (CDT D8080) in order to stop the abuse of providing cosmetic, not medically necessary, treatment."

2019 GLMS MEDICAID ROUNDTABLE ISSUES

PASSPORT HEALTH PLAN Roundtable Questions Submitted	
Passport Health Plan Question 1	How are we supposed to reserve funds beforehand if we do not know the exact code that will be billed for new patients? We bill dental codes and as such, are now subject to having to reserve funds under the patients "My Rewards" program. We are an oral surgeon office and when a patient is scheduled we don't know exactly the code we're going to use. It can vary based on if we have to end up taking an x-ray, or if a tooth is impacted or not. But the way the system works (to my understanding) is that before the patient comes in, we have to reserve funds from their My Rewards program in order to get paid through Medicaid for their visit. *(Stacy Boros, Greater Louisville Oral & Maxillofacial Surgery)*
Response:	**4/9/19 Responses from Passport:** We will be in contact with the provider regarding this issue.
Passport Health Plan Question 2	Eligibility issue Passport shows patient as active third party vendor Evicore shows patient inactive. We call Passport to have them send a case to Evicore takes about 3 weeks to a month to update. 3 weeks later the patient is inactive again and the process starts over. Unable to obtain authorization as long as Evicore shows patient inactive. *(Jessica Armpreister, Commonwealth Pain Associates)*
Response:	**4/9/19 Responses from Passport:** We will be in contact with the provider regarding this issue. **Further info from 4/10/19 Roundtable:** Passport will meet with Practice after panel discussion to address this issue.
Passport Health Plan Question 3	ALL MCO ISSUE: Is an Orthognathic Surgery approval required prior to patients starting Orthodontic treatment (braces) that will later require jaw Orthognathic Surgery. Would like a fee schedule of covered codes Medical and Dental. *(Bridget Lanier, University of Louisville Dental Associates)*
Response:	**4/9/19 Responses from Passport:** Orthognathic Surgery does require medical necessity review. The fee schedules are on the DMS website.
Passport Health Plan Question 4	Please provide an an update on the status of Passport's contract with the state as a Medicaid MCO and plans moving forward. *(GLMS)*
Response:	**Info from 4/10/19 Roundtable from Passport Medical Director, Dr. Steve Hoagland:** In general, Passport Health Plan maintains a good working relationship on a day-to-day basis with our partners at KY DMS. We're working with the Department of Insurance as a result of some of the risk based capital reporting that came in at the end of the year. Our plan and intention is to execute on the contract that we have in place. When there is a solicitation that comes out (from DMS), our intention is to provide a winning response subject to all the activities around that. If there are specific questions, I can work towards answering those.

2019 GLMS MEDICAID ROUNDTABLE ISSUES

WELLCARE Roundtable Questions Submitted	
Wellcare of KY Question 1	Is there any way that you could format your ID numbers so that it would be recognized as a Medicaid number immediately? Maybe use "MC" at the beginning of the ID for Wellcare Medicaid patients or just state if it starts with 1, 2, or 3 it is Wellcare Medicaid or Wellcare Medicare. *(Lois Sheffield, Rehabilitation Institute, PLLC)*
Response:	**4/9/19 Responses from Wellcare:** We are unable to change the format for our Medicaid ID numbers.
Wellcare of KY Question 2	ALL MCO ISSUE: Is an Orthognathic Surgery approval required prior to patients starting Orthodontic treatment (braces) that will later require jaw Orthognathic Surgery. Would like a fee schedule of covered codes Medical and Dental. *(Bridget Lanier, University of Louisville Dental Associates)*
Response:	**4/9/19 Responses from Wellcare:** Avesis handles all dental codes for WellCare and authorization would be requested via their process. WellCare handles medical codes and authorizations would be requested following the WellCare authorization process. WellCare follows the Kentucky Medicaid Fee Schedule. Please see the appropriate fee schedule on the Kentucky DMS fee schedule for covered codes.

2019 GLMS MEDICAID ROUNDTABLE ISSUES

KY DMS (DEPT FOR MEDICAID SERVICES) Roundtable Questions Submitted	
DMS Question 1	Since Kentucky HEALTH was halted again for the work requirements, what are the plans moving forward for this program? *(GLMS)*
Response:	**4/10/19 Roundtable:** We are continuing to operate as we have been since 4/1 and we are evaluating with the Department of Justice regarding this decision and how we will move forward.
DMS Question 2	What is the current status of the Medicaid MCO RFP? Will there be a limit to the number of MCOs chosen by the state? When will new MCO contracts take effect? *(GLMS)*
Response:	**4/10/19 Roundtable:** We are currently in a blackout period so I cannot respond on the RFP.
DMS Question 3	ALL MCO ISSUE: Is an Orthognathic Surgery approval required prior to patients starting Orthodontic treatment (braces) that will later require jaw Orthognathic Surgery. Would like a fee schedule of covered codes Medical and Dental. (*Bridget Lanier, University of Louisville Dental Associates)*
Response:	**4/10/19 Roundtable:** We leave this up to the Managed Care companies to determine how they process it. It has to be medically necessary in order to be covered under the EPSDT.

Questions/Discussions During Roundtable 4/10/19	
Anthem Q3: Modifier 25	What about dermatology? Is that considered a major surgery?
Response:	Anthem: Major surgeries with Modifier 57 are your globals. Modifier 25 are zero or ten day globals. So, if you have a new patient come in and you do an incision on the same day and Modifier 25 is applied to the E/M and the claims will go through.
Anthem Q3: Modifier 25	What about through the ER Department? In this scenario, we've never seen this child, they show up in the ED and are evaluated and are sent to surgery?
Response:	**Anthem:** In that case, you saw the patient through the ER and there was a same-day decision for surgery, it should go through. The whole point of the Modifier 25 issue is to determine the sole purpose of the patient's visit. APC has some good information on their website about when it's appropriate to bill modifier 25 and when it isn't appropriate.
Anthem Q3: Modifier 25	When you say that you will be taking a closer look at Modifier 25, will you be requesting medical records?
Response:	**Anthem:** If you bill with the Modifier 25, it may be pended requesting medical records. I'm not sure if everyone is aware of this, but you CAN upload medical record documentation on Availity and it will link it directly to the claim. That is what you would have to do if it was pended or you were waiting for your claim to come through. But no, not every claim with modifiers will be pended.
KY DMS	What percent of patients were determined medically frail in preparation for the 4/1/19 Kentucky HEALTH implementation?
Response:	**Angie Parker, DMS:** I don't have that number on me. It's dependent on a lot of factors.
KY DMS	If DMS shows eligibilty for a patient but Passport does not, who is ultimately responsible for fixing that information?
Response:	**Angie Parker, DMS:** Medicaid's list is the most accurate, always. We would probably need to look at the member and it might be a system issue for Passport. I can get with you after this but our system is the truth.
KY DMS	How do we verify eligibility without a social security number or a member ID number?
Response:	**Angie Parker, DMS:** Provider Services should be able to help, however we are not sure if eligibility can be obtained without either the social security numbe OR the member's Medicaid ID number. Will follow up with an answer through GLMS.

KY DMS - Co-pays	Is there a way to verify if a patient has a co-pay or not?
Response:	**Angie Parker, DMS:** This information can be obtained from the eligibility site when confirming eligibility.
KY DMS	With a homeless patient, what is the minimum criteria you all need to sign-up a patient for Medicaid? How can we provide care for the patients that might not have a real home address or a P.O. Box?
Response:	**Angie Parker, DMS:** We can get that answer for you.
KY DMS/ALL MCOs	I'm in the process of changing our practice's name--our tax I.D. and NPI have stayed the same but we're wondering at what point do we change it in our system and will a claim get denied if it doesn't match?
Response:	For Aetna, your claim should not deny but if you stop over at our table afterwards and give us your email address and send us your new practice name we'll have it updated for you immediately. Same with Humana CareSource. Name changes need to be done through the state first then once approved, request changes through MCOs.
Passport Referral Process	Since Passport did away with the referral form, what exactly does a specialty practice need to document in the patients file for a referral?
Response:	I'll get with you afterwards and give you some information about what is required for specialty practices. You're right, our process has changed. We want our old model to remain in place to make sure that the care is coordinated with the PCP and to show that it is in the record even though a specific form is no longer required.
Passport Q4	What happened to Evolent? Is there still a partnership between Passport Health Plan and Evolent?
Response:	**Passport:** Evolent is still a business partner with Passport. They provide a number of services for us including providing the platform for claims processing and acting as a third-party administrator. They also help provide analytic support for us as well as the activities on a day-to-day basis for utilization management and helping to manage our pharmacy services.
Passport-Checking Eligibility	Is there anything you can do to make checking eligibility easier?
Response:	**Passport:** Our provider portal should help with making that easier and we can help with training your staff on using that portal.
Wellcare-Patient Attributions	Regarding Patient Attribution Reports: Will a practice be penalized for not meeting the criterias for a patient that has been assigned to us but is not our patient?

Response:	**Wellcare:** Every quarter we will run a report that lists every Wellcare member and if a member that has been attributed to your practice has been seen by another PCP in the last 2 years and there's claims data to support that, then they will be moved to the other practice in an effort to clean up that process. So, those that remain on your panel have no claims data to support them having seen another PCP. We do know that a small percentage of our Medicaid and Medicare population do not go anywhere. Every provider has some of those on their panel. But, we do make every effort to identify those that are being seen elsewhere and move them so that it doesn't penalize you and so that the physician that is seeing that person gets credit for the work and care that they are providing.
Wellcare Case Management	What about those patients that are not seeing a PCP and are only being seen in the ER?
Response:	**Wellcare:** We do have case management and member services that reach out to those patients that are identified as not seeing any PCP and are going to the ER. One of the biggest barriers for Medicaid members is non-emergency transportation, and so we give them a phone number and other information to assist with this.
Wellcare	Does Wellcare follow the DMS codes? KY DMS will pay for some things that Wellcare won't pay for.
Response:	**Wellcare:** Yes, we do follow the fee schedule on the DMS website. If you have specific examples, we can talk after this and we'd be happy to help you.
Wellcare-Patient Attributions	We are a pediatric practice, how do we get adult patients off our panel that were incorrectly automatically assigned to us and how long should it take? We have sent multiple requests to have people removed.
Response:	**Wellcare:** It should be quicker than what it sounds like you are experiencing. If you want to talk afterwards, we can help to show you what we can do to expedite that process for you. We want to make sure that we have the ages of those patients listed correctly so that it doesn't continue to happen and that we don't continue to attribute patients that are 18+ or 21+, depending on your cut-off, to your practice.
Same as above Question	Same scenario--some patients have never been seen by our practice, it is a waste of time to reach out to these people because we have not seen them even if Wellcare says that we have. Our panel should be closed.
Response:	**Wellcare:** We would want to verify that your panel is closed because if it is, you would not be receiving membership attributions. If you do have those patients on there that are not supposed to be on there, we will work with you to get those removed

PAYER UPDATES / NEWS

AETNA BETTER HEALTH	Changes to Network Relations team - information on provider portal
ANTHEM MEDICAID	Anthem Medicaid changing credentialing systems to ENCRED for ALL IN Medicaid Managed Care Organizations effective 7/1/19. Blackout period in June. Contact Sophia.Brown@Anthem.com
	Provider rep changes. Jennifer Smith and Kristin Miracle will be splitting Jefferson Co and So. IN zip codes. Updated map of territories will be on website soon. Practices will have one point of contact moving forward.
HUMANA CARESOURCE	Realigned Provider Engagement Team - listed online
PASSPORT	Provider Satisfaction survey link online
	Community engagement opportunities
	Check the provider portal for more updates, training requests and forms
WELLCARE	Annual Provider Summit - Fri, 5/24/19 8:30a.m.: Shelby Campus
	Community Connection opportunities
	Mobile app for patients to view ID cards, care gaps and provider contact information