health allies

Health Allies Counseling

Chair Nosse and the Members of the House Committee on Behavioral and Health Care

My name is Tiffany Kettermann, I am an LPC in Oregon, the owner of a group practice with 25 therapists, an active board member of COPACT, and one of the authors of this bill.

Audits are an abusive game in our career field; one in which insurance companies hold all of the power, and mental health providers across the state are powerless. **We are asking you to pass HB2455 to help protect therapists so they can stop living in fear of having their livelihood destroyed and focus on doing their work to support the mental health needs of Oregonians.**

When therapists graduate from college, they have been trained in all aspects of counseling to prepare them for this field except for one. There is not one class in how to pass an insurance audit or bill an insurance company in school. Once therapists are out working in the field, **there is not one insurance company that provides specific information on how specifically to document services to pass an audit**. Our own team, including a QA manager who has over a decade of experience in mental health audits, has invested hundreds of hours reviewing state statutes, as well as the contracts, handbooks and websites of every major insurer we are contracted with. This includes eight private and three Medicaid insurers. Only three provide any attempt at directions for how to complete documentation. However the information provided from those three companies does not cover all the standards of what we or others we know have been audited to.

Therapists learn what is specifically expected in their documentation after an audit has been completed and we are asked for thousands or hundreds of thousands of dollars back. Even that result can change depending on the auditor. The incredible stress and fear, coupled with the financial damage and time that this process involves… causes providers to leave individual insurance panels or the entire field of therapy. At a time when access to care is critical, this needs to stop.

Especially since the surge in demand for mental services began in 2020, audits have skyrocketed against providers. **One 2022 study cited mental health attorneys reporting a 40% increase in mental health audit cases.** While we agree that audits are necessary for insurance companies to protect against fraud, the recoupment we have seen in audits have very little to do with fraud. In fact, a review of the public disciplinary records from the OBLPCT shows there are two cases of billing or documentation fraud across all of the approximately 245 disciplinary actions since 2008. That's two cases of fraud found in 15 years. And yet I know dozens of therapists paying back tens of thousands of their hard earned money every year, or worse, quitting the field entirely due to fear of audits.

Add to this that since 2020, in order to have enough therapists to serve increased demand, insurance companies are now allowing associates, that's prelicensed therapists, to bill insurance companies straight out of college. Before this, they needed to complete an additional 2-3 years out in the field. This is a much needed development in our field that increases access to care. However, the vast majority of associates run eagerly into practice, completely unaware of the danger they are walking into, no knowledge of how really abusive the documentation standards will be, and not setting money aside for the inevitable recoupments they are facing. This sets them up for an incredible amount of damage.

As a business owner, I invest hundreds of thousands of dollars in administrative costs annually in protecting my staff – money that would be much better spent in therapist wages. I have four full time and one part time staff overseeing documentation of 25 therapists, trying to support and protect them; that's one full time person needed for every five therapists and over 180 weekly hours of just supporting our therapist in being able to meet audit requirements. We have invested in investigating rules, pressing for answers, scouring our records, developing processes and training, support sessions for providers, fighting back in our own audits, and I have to set aside a large sum of money for inevitable recoupments.

Last year we were audited twice. In one of our audits, OHA asked me to send back 100% of all payments they made to me over a 6 month period from several years ago when I was a solo provider. The recoupment was $19,000 and would have had to been paid back in one lump sum instantly. That amount would have bankrupted me if I were still a solo provider. They weren't even applying the correct statutes to my documentation, nor auditing the current time period that triggered the audit. They went back to a time period years ago when I was seeing the most of their clients, so they could make the most money back. It cost me hundreds of hours to fight it by explaining to them which statutes they were applying to me that didn't legally apply to me. After legal consultation sending around 50 pages of arguments back to them, I got it reduced down to 30% and almost $6,000. None of the issues I paid back for were issues related to quality of care. Thirty percent for us now in a Medicaid recoupment would be over $500,000.

Auditors not knowing their own rules or consistently applying their own rules is common. Its up to the provider to educate themselves and fight back, or spend thousands in legal fees. By asking insurance companies to provide directions for audits, we are holding insurance companies accountable to knowing their own rules before they enforce them. This step alone would increase therapists' sense of safety in the audit process.

The audits we have been through and the daily fear of future audits has completely burned out and exhausted my staff. We lost several of our most experienced and skilled therapists; they went into private practice and planned to stop taking insurance.

Understand that the details that are causing recoupments have nothing to do with quality of care: its forgetting credential initials in a signature, or writing the time and length of the appointment inside the note, not realizing that the insurance company also wants you to change the appointment time on your calendar too. Its providing too many 53 minute sessions compared to our peers. Its not documenting to their vague standards about what constitutes medical necessity, which can change depending on which auditor is reviewing your records. Some insurance companies will even tell you they don't have to tell you why they are recouping. In fact we are told to never expect to pass an audit, so we work to set aside 15% of our income to prepare for the next one. I have attached a list of some of the reasons we've been given for failing progress note documentation, which is only one of several aspects of documentation that are audited.

Finally, we worked with the Oregon Health Authority on the amendments to this bill to ensure that the bill complies with Medicare Fraud and Abuse standards. They reviewed the bill and provided feedback so we could ensure it was in compliance. We also looked at how other states handle lookback periods and our proposal is in alignment with other states. Finally, we utilized Oregon statutes and found that OAR 407-120-1505, paragraphs 17 and 18 support our request for payment plans to be more accessible and flexible.

Audits should not be considered a lucrative income stream for insurance companies. We are asking for your help to give us legal rights to transparent rules in how to pass an insurance audit so that therapists across the state can safely take insurance, as well as for the most basic of rights in audits. Protections like shortened lookback periods, ending statistical sampling, and payment plans do not reduce insurance's protection against fraud and only serve to increase the fairness in audits. **Most importantly, they will allow therapists to safely take insurance, and increase access to care. Please pass HB 2455.**

ATTACHMENT:

Exanples of actual feedback we have received in audits of our progress notes that were rules not specified anywhere. We have similar lists for treatment plans, assessments as well as many other requirements to follow. This is in addition to the statutes or directions we were given.

- start/stop time or duration doesn't match the calendar start/stop time or duration
- do not vary enough in start/stop times or duration that they claim is "not accurate"
- don't include enough examples of interventions or client responses
- don't include enough, unknown number, of client direct quotes
- do not have specific examples of symptoms and functional impairments
- don't include clear enough examples of evidenced based treatment modalities/interventions
- doesn't have "clear" link to the treatment plan
- intervention isn't clearly described regarding what was resolved
- doesn't state modality used and only interventions are described
- reads as a report of the session and it's not clear was resolved
- not completed within 2 days from date of service
- not signed within 2 days from date of service
- provider signature does not include credentials written in a specific way
- any duplicated or copied over information from prior progress notes
- don't include specific cultural information identified/included
- don't include case management or coordination of care
- don't include the exact goal/objective being addressed
- missing measurable stated progress towards the plan/objective
- any sections that are missing any information
- for a date of service in which the assessment / treatment plan has not been updated within the past year
- for 53+min sessions and there is not "enough" in the progress note to justify extended session length
- does not have a clear safety plan for any risks, even if a prior one is in place