OREGON INDEPENDENT MENTAL HEALTH PROFESSIONALS

To: Cassandra Soucy and HB 3046 RAC Members

From: Melissa Todd, Ph.D., representing OIMHP

Date: December 3, 2021

Re: Comments on HB 3046 Section 5 rulemaking

Thank you for the opportunity to participate in the Rulemaking Advisory Committee for HB 3046. OIMHP wishes to contribute language to help specify rules to assure the proper implementation of HB 3046 Section 5, with particular attention to Section 5(12) as stated below:

> *The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section. The director shall adopt rules making it a violation of this section for a group health insurer or issuer of an individual health benefit plan other than a grandfathered health plan to require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity.*

We make these recommendations after consideration of historical and new emerging practices by insurance carriers designed to suppress the utilization of and payment for the 60-minute psychotherapy code, CPT 90837, for behavioral health (BH) providers.

1. Insurers, issuers**,** or their representatives shall not create rules to restrict the use of a billing code beyond the description of the code's procedures specified by the current edition of the official CPT codebook published by the American Medical Association or further specified by valid, evidence-based sources cited in Section 5(1)(n)**.**

2. Insurers, issuers, or their representatives shall not give behavioral health providers written or oral guidance about billing or utilization, including guidance based on claim data analytics, that a reasonable provider would understand was intended to discourage or restrict the use of a specific billing code beyond the description of the code's procedures specified by the current edition of the official CPT codebook published by

the American Medical Association or further specified by valid, evidence-based sources cited in Section 5(1)(n)**.**

3. Insurers, issuers, or their representatives shall not initiate pre-payment or post-payment audits of a specific billing code unless there is evidence that a behavioral health provider is using the specific code in way that is not consistent with the description of the code's procedures specified by the current edition of the official CPT codebook published by the American Medical Association or further specified by valid, evidence-based sources cited in Section 5(1)(n)**.**

4. Insurers, issuers, or their representatives will not develop unique or atypical methodology to establish behavioral health provider reimbursement rates in a way that will restrict or reduce payment for any specific behavioral health time-based office visit billing code that it does not also use to restrict or reduce payment for any specific medical or surgical time-based office billing code. This rule will be consistent with Sections 5(2)(g), (h), and (i).

To support the need for the aforementioned rules, we offer the following information on the background of 2013 CPT coding changes, subsequent efforts by insurance carriers to suppress the use of CPT code 90837, and recent troubling activities reported by Oregon BH providers.

2013 CPT Code Changes

On January 1, 2013 the American Medical Association (AMA) released a new family of psychotherapy CPT office visit billing codes. Their AMA/Specialty Society Relative Value System Update Committee (RUC) determined the need to update these codes after a 5-year investigative review, involving input from health care surveys and expert panels of health care professionals. The RUC recommended numeric work values for these codes, referred to as *relative value units (RVUs),* which represent the value of a given service relative to all other services based on the amount of provider work, resources, and expertise required to deliver that service to patients. The new 2013 psychotherapy office visit CPT codes and accompanying RVUs were approved and published by the Centers for Medicare and Medicaid Services (CMS) in the Federal Register.

The old family of psychotherapy billing codes (90804: 20-30', 90806: 45-50', and 90808: 75-80') was eliminated and replaced by the new codes which remain in use today (90832: 30', 90834: 45', and 90837: 60'). The coding changes reduced the prior gap between the two longest office visits from 30 minutes to 15 minutes. Prior to 2013, most BH providers billed the 45-50-minute code, 90806, for psychotherapy. If they spent more time, they would typically "down code" due to the large time gap to 90808; *in other words, BH providers would often forego reimbursement for additional time and work with their patients*. However, once the new 60-minute psychotherapy code, 90837, was established, BH providers started billing this code as intended by the AMA.

Since CMS had assigned a higher RVU to 90837 than to 90834 to compensate for the additional 15 minutes of service, the 90837 rate appropriately increased over 90834 when insurance carriers used the resource-based relative value scale (RBRVS) methodology to set reimbursement rates. RVUs determine provider compensation when the conversion factor (dollars per RVU) is applied to the total RVU. Carriers routinely use the RBRVS methodology to set reimbursement rates for medical providers, resulting in higher payment for longer medical office visits based on higher assigned RVUs. However, very soon after BH providers started billing for 60-minute psychotherapy office visits, some insurance carriers and affiliated managed care companies developed ways to restrict payment of the associated 90837 code.

Senate Bill 860 Findings

As required by SB 860 (2017), DCBS conducted an examination to determine whether BH office visits generally, and CPT code 90837 specifically, were paid in a manner equivalent to the payment of medical office visits. Their examination found that 91% of the 11 examined carriers (covering all but 1.8% of all commercially insured Oregon consumers in 2018) established their medical provider rates using the RBRVS system. However, only 3 of 11 insurance carriers (covering about 25% of all commercially insured Oregon consumers in 2018) established their BH provider rates using the same RBRVS methodology in the same basic way. *So nearly 75% of Oregon carriers reimbursed BH providers differently than medical providers in a way that suppressed rates for BH services.* These carriers often developed their own "internal fee schedules" for BH providers, which were not based on relative work values, were not developed using an identifiable methodology, and were not updated each year as was true of most medical provider fee schedules.

Since 2013, many Oregon insurance carriers have restricted payment of 90837 and other BH CPT codes identified by the Oregon SB 860 Final Report produced by Risk and Regulatory Consulting, LLC (RRC) for DCBS, published March 31, 2020. These restrictions have included:

- Using "internally developed" non-RBRVS methodology to establish payment for 90837 and all other BH office visit codes (40% of Oregon carriers covering 27% of all commercially insured Oregon consumers in 2018). This percentage included one carrier that paid 90834 and 90837 at exactly the same rate despite the 15 minutes of additional time and work for 90837. These internally developed rates were rarely updated and carriers were usually at a loss to explain to RRC how their rates were established.

- Using the RBRVS methodology to establish most BH provider office visit rates with the exception of 90837, specifically suppressing only the 90837 code by paying it a "fixed fee" (9% of Oregon carriers covering 26% of all commercially insured Oregon consumers in 2018).

- Using utilization management procedures to examine BH office visit claims for medical necessity, while not examining medical office visit claims in an equivalent manner, including some combination of preauthorization, concurrent review, retrospective review, and outlier management procedures (45% of Oregon carriers covering 25% of all

commercially insured Oregon consumers in 2018). The RRC's *SB 860 Volume 1: Background and Executive Summary* reported, "in summary, the utilization management requirements for BH Providers were noted to be more restrictive than the requirements for Medical Providers" (p.18). For example, for the 56% of carriers that had in place concurrent review, retrospective review, or outlier management requirements, *80% of these carriers had requirements that only applied to BH Providers.*

Some insurance carriers have justified their suppression of the 60-minute 90837 code by arbitrarily claiming the 45-minute 90834 code to be the "industry standard." In reality, the AMA established new office visit code options in 2013 to remedy an impractical time-gap and allow for BH providers to be appropriately reimbursed for their time and work. This arbitrary claim has characteristically been declared by the very same carriers who have failed to update their BH provider reimbursement rates over time, sometimes decades, while routinely updating and increasing their medical provider rates.

Recent Events in Oregon

In recent weeks, several Oregon BH providers have informed OIMHP about a new and aggressive 90837 review and management procedure conducted by a large Oregon insurance carrier through their contracted third party organization, Change Healthcare. Consequently, Change Healthcare provided a written statement to the HB 3046 RAC on September 9th, 2021, advocating for flexibility in rulemaking to allow for the continued use of third party clinical criteria used to determine medical necessity for BH care services.

Oregon BH providers have received letters from Change Healthcare informing them of a "Coding Advisory Program" designed to review use of CPT code 90837, referred to as a "high level code." The letters purportedly compare a provider's utilization of 90837 with other providers "within the same specialty" (specialty undefined). The letters go on to say that this program is "informative in nature and is not intended to question a provider's treatment methods or clinical judgement." However, the letters further state that the provider's "billing trends" will continue to be monitored and "if subsequent analysis reveals the proportion of reported high-level codes continues to exceed the expected distribution," Change Healthcare "may contact your practice for the purpose of further validation and education" and will report this information to the insurance carrier. This can only be considered intimidation, despite being characterized by Change Healthcare as "informative."

This insidious utilization management practice is clearly designed to reduce BH provider use of 90837 in the short term; however, the real impact will be the long term reshaping of provider billing practices to reduce the overall use of 90837, thus creating a statistically manipulated argument that frequent use of 90837 is atypical. Change Healthcare is playing the long game at the expense of Oregon BH providers and their patients.

It should be noted that the AMA CPT codebook uses only *the amount of time spent with a patient and/or family member* to distinguish whether to bill CPT code 90832, 90834, or 90837; there is no statement of what code is considered standard or typical. It is thus unclear why

Change Healthcare is specifically singling out 90837 to seek "further validation and education." It is difficult to imagine the sponsoring carrier enacting an equally aggressive review of physician time-based office visits despite physicians being allowed in 2021 to bill for the amount of office time spent, *including both face-to-face and non-face-to-face activity*.

Beyond the prima facie declaration of Change Healthcare claiming its efforts are "informative," this third party company is now playing a role in rejecting claims for 90837 at the electronic clearinghouse level. One BH provider reported to OIMHP that 90837 claims were being rejected prior to processing with the explanation:

> "PROCEDURE CODE: ADVISOR ALERT; PROVIDER CLAIM HISTORY IDENTIFIED AS OUTLIER FOR BILLING OF HIGH LEVEL BEHAVIORAL HEALTH CODES. PLEASE CONFIRM VALIDITY OF CODING AND RESUBMIT THE CLAIM. FOR QUESTIONS CALL CHANGE HEALTHCARE."

In other words, BH providers who utilize 90837 must submit their claims twice in order to be reimbursed. One would have to engage in strenuous mental gymnastics to view this practice as a legitimate monitoring of medical necessity, rather than as an effort to restrict payment for BH services in violation of the federal and Oregon mental health parity laws.

House Bill 3046 was passed overwhelmingly by the Oregon legislature precisely to neutralize the practices of insurers, and their third party representatives, which discriminate against BH providers and their patients with utilization management based on metrics and cost to the insurer, and not on medical necessity or provider discretion. The tactics being employed by Change Healthcare – and the insurers they contract with – are a clear violation of both the spirit and the letter of HB 3046 and must be prohibited.