OREGON INDEPENDENT MENTAL HEALTH PROFESSIONALS

To: Brooke Hall and HB 3046 RAC Members

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

Date: April 13, 2022

Re: Comments on HB 3046, Section 8

Thank you for the opportunity to participate in the Rulemaking Advisory Committee for HB 3046. OIMHP would like to offer guidance on rulemaking for Section 8(5)(a)(C) as stated below.

> *For medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions that does not involve level of care placement decisions, other criteria and guidelines may be utilized if such criteria and guidelines are based on the current generally accepted standards of care including valid, evidence-based sources and current treatment criteria or practice guidelines developed by the nonprofit professional association for the relevant clinical specialty. Such other criteria and guidelines must be made publicly available and made available to insureds upon request to the extent permitted by copyright laws.*

We concur with NAMI Oregon and their coalition partners, as stated in their March 3rd, 2022, memo, and request that DCBS to examine and pre-approve *other criteria and guidelines* used by insurance carriers and contracted third party organizations for non-level of care review **prior to usage**. This process would ensure carrier-designed review criteria would be based upon *current generally accepted standards of care*. For a concrete example of how Oregon behavioral health (BH) providers are currently being subjected to review tactics that violate HB 3046, please refer to OIMHP's December 3rd, 2021, memo. We reported that a third party organization, Change Healthcare, is conducting an aggressive review and management program designed to suppress behavioral health providers from billing CPT code 90837 for reasons other than medical necessity. Attached are two letters from Change Healthcare to Oregon BH providers for your reference. We believe the letters speak for themselves, and provide ample support for adopting rules that take a proactive approach, putting the onus on insurers to prove compliance prior to applying review procedures based on criteria other than those developed by nonprofit professional associations.

To ensure that insurers and contracted third party organizations demonstrate that review procedures based on *other criteria and guidelines* are in compliance with HB 3046, we recommend that DCBS examine:

1. Whether the review criteria is singling out a particular billing code (e.g., CPT 90837), prohibited in HB 3046 Sections 5(12) and 8(13), rather than applying the criteria to an entire service category as identified by the MHPAEA (e.g., outpatient office visits).

2. Whether the review criteria explicitly defines how it is based on *current generally accepted standards of care*, rather than a statistical outlier management system based on frequency of billing code use (e.g., Change Healthcare's "Coding Advisor Program" currently being implemented in Oregon).

3. Whether there is basis for the claim by some insurers and contracted third party organizations that specific CPT billing codes are non-standard, atypical, high-level, and/or extended, given that the AMA CPT code book does not define a generally accepted standard of care in the description of billing codes commonly subject to review (e.g., CPT 90837).

4. Whether the review criteria adequately defines and details factors underlying a NQTL's application and shows that the factor is applied in a comparable way across BH and medical providers and services (e.g., "billing trends," "high-level codes"). Please see the 2022 MHPAEA Report to Congress, pg. 17, for context.

5. Whether the insurer and contracted third party organization is applying their review criteria equivalently and no more stringently to BH providers and services than medical/surgical, including non-behavioral medical providers and services.

6. How insurers and contracted third party organizations are enforcing provider compliance with review criteria (e.g., rejecting claims at the clearinghouse level, blocking payment of claims submitted) and whether they are applying enforcement strategies equivalently and no more stringently to BH than medical/surgical.

For additional guidance relevant to Section 8, please refer to the OIMHP memo from December 3rd, 2021, offering rule language for Section 5(12), which is identical to Section 8(13), and makes it a violation for insurers *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.*

The 2022 MHPAEA Report to Congress shows a failure by insurance carriers to deliver parity for mental health and substance use disorder benefits, and supports greater monitoring and enforcement efforts by regulators to facilitate access to treatment. We advocate for Oregon to follow suit by establishing administrative rules to close loopholes and ensure proper implementation of HB 3046.

CHANGE HEALTHCARE

September 30, 2021

[redacted]

Regence BlueCross BlueShield of Oregon contracted with Change Healthcare to implement the Coding Advisor Program in order to review the use of Psychotherapy codes. As part of this partnership we have analyzed claim data between July 2020 and June 2021 for the purpose of identifying providers who are billing high-level codes significantly more often than other providers within the same specialty. As demonstrated in the attached report, your billing of these services is considerably greater than the expected billing distribution of your specialty group. It is important that your practice understands and abides by the applicable documentation and reporting guidelines to ensure that the medical records support the services provided. The Change Healthcare Coding Advisor Program is intended to be informative in nature and is not intended to question a provider's treatment methods or clinical judgement.

Continuous Monitoring

Change Healthcare will continue to review your billing trends. We will periodically send you updated reports pertaining to how the quarterly review of your claim activity compares to other providers within your specialty and will share these results with Regence BlueCross BlueShield of Oregon. If subsequent analysis reveals that 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.

At any time, we offer the opportunity for you to engage with Change Healthcare's mastery level professional coders for further education and information on your claim submission practices.

Taking an Active Role

Change Healthcare is aware many factors may impact the coding of services rendered. We welcome the opportunity to collaborate with your practice. We encourage you to reach out to the Change Healthcare Coding Advisor Customer Service Support line at 844-592-7009, Option 3 or by mail at 701 E. 22nd Street, Suite 200, Lombard, IL 60148 Attn: Coding Advisor Dept to learn more about the Coding Advisor Program and how we can help with claim submission practices.

Sincerely,

C. Hall

Chris Hall, HCAFA
Senior Director of Operations, Change Healthcare

Attachment(s):
Psychotherapy Report

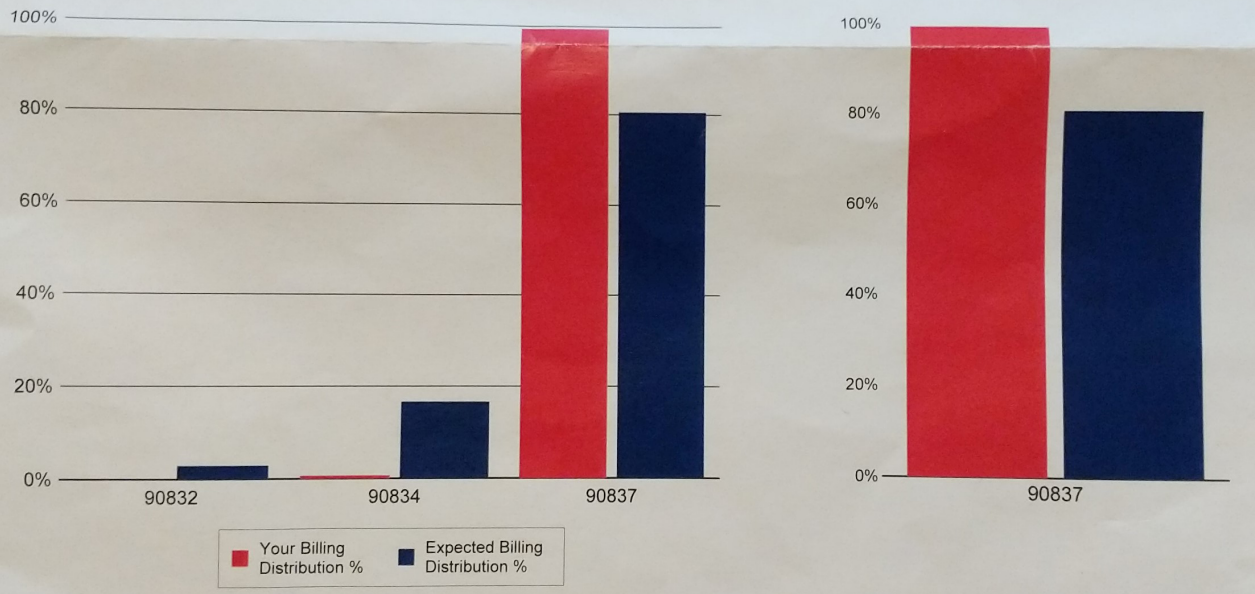
[redacted]

CHANGE HEALTHCARE

Psychotherapy Visits Report

Total Qualified Occurrences: [redacted]
Total Qualified Billed Charges: [redacted]

Procedure Code Range	90832	90834	90837
Your Billing Distribution[1]	[redacted]		
Your Billing Distribution %			
Expected Billing Distribution %[2]			



Criteria for submitting a 90837 code:

-Psychotherapy times are for face-to-face services with the patient and/or family member.
-The patient must be present for all or some of the service.
-In reporting, choose the code closest to the actual time (i.e., 53 or more minutes for 90837); some carriers may require documented start and end times.
-Documentation supporting medical necessity.

Footnotes

1. Data represents claim paid dates from 7/1/2020 to 6/30/2021 where psychotherapy codes 90832, 90834, 90837 were reported.
2. Expected Billing Distribution represents average distribution of psychotherapy codes billed by providers within the same specialty.

[redacted]

CHANGE HEALTHCARE

February 28, 2022

[redacted]

[redacted]

Dear [redacted]

Regence BlueCross BlueShield of Oregon has contracted with Change Healthcare to review the use of Psychotherapy codes for all providers as part of ongoing claim review activities. Change Healthcare originally analyzed the claims between July 2020 and June 2021 for the purpose of identifying those providers who are billing high-level codes significantly more often than other providers within the same specialty.

A mailing was sent on 9/30/2021 demonstrating that the percentage of high-level codes billed by your office was greater than the expected billing distribution as was determined by the average billing behavior of other providers within your specialty. We understand Psychotherapy services often help avoid additional and more expensive medical services. These mailings are intended to be informative in nature and not intended to question a provider's treatment methods or clinical judgment.

CONTINUOUS MONITORING

Change Healthcare has performed a subsequent analysis based upon October 2021 through December 2021 paid claims; the detailed results are attached in the updated Psychotherapy report. The analysis indicates that the percentage of high-level codes billed is still greater than other providers within your specialty. Change Healthcare will continue to review your billing trends and will send updated reports periodically. If subsequent analysis reveals that 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.

CLEARINGHOUSE MESSAGING REMINDER

As previously mentioned, Change Healthcare's Coding Advisor Program may use clearinghouse electronic data interchange (EDI) transaction technology to notify providers of their high-level Psychotherapy submission status at the point of claim submission through industry standard claim status messaging. You may have received an aforementioned Coding Advisor message upon submission of a qualifying claim. At the time that you received that message, we asked that you review the patient's medical records to confirm that they accurately reflect the services provided and the documentation meets criteria to support the services reported, as per the patient's Health Plan documentation guidelines. All claims must be resubmitted, whether or not changes are made, in order to be sent to the plan for adjudication.

TAKING AN ACTIVE ROLE

Change Healthcare is aware many factors may impact the coding of services rendered. We welcome the opportunity to collaborate with your practice. If you have not done so already, we encourage you to reach out to the Change Healthcare Coding Advisor Customer Service Support team, with your reference number, by phone at 844-592-7009, Option 3, or by fax at 615-238-0834, or email CodingAdvisorSupport@changehealthcare.com to learn more about the Coding Advisor Program and how we can help with claim submission practices.

Sincerely,

C. Hall

Chris Hall, HCAFA
Senior Director of Operations, Change Healthcare

Attachment(s):
Psychotherapy Report

[redacted]

CHANGE HEALTHCARE

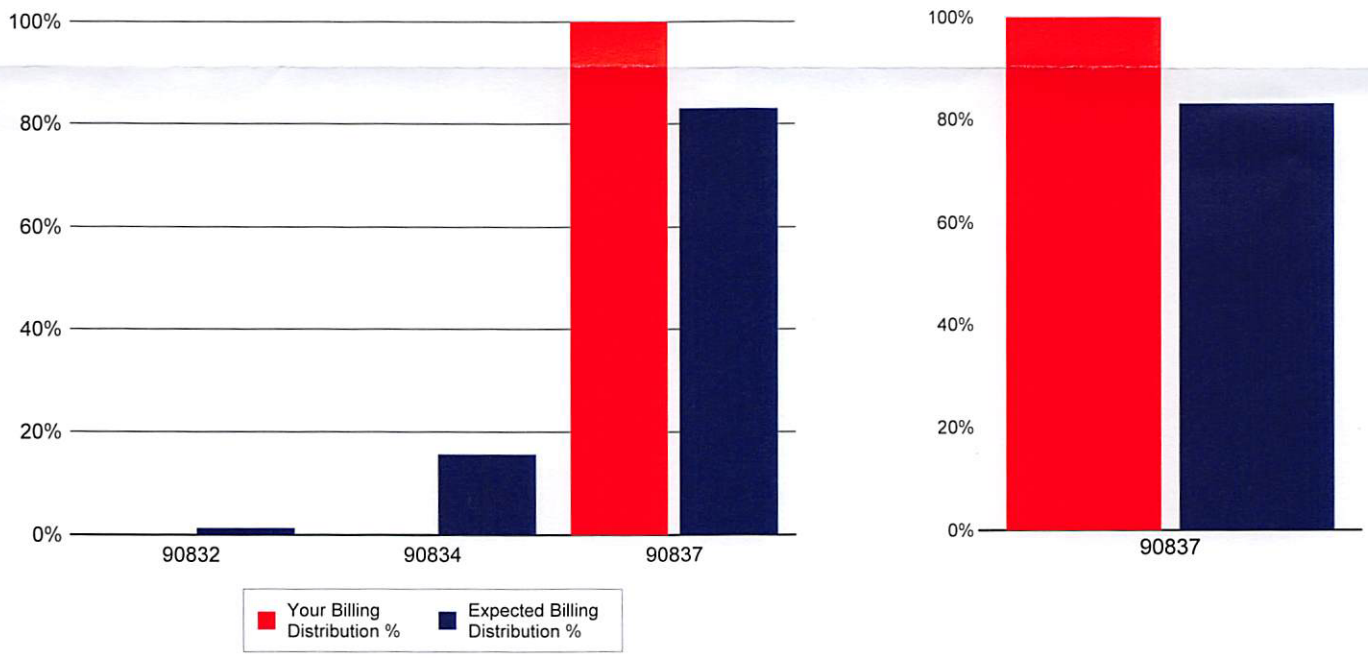
Psychotherapy Visits Report

[redacted]

Specialty: Counselor: Professional
Age Range: 19-44

Total Qualified Occurrences: [redacted]
Total Qualified Billed Charges:

Procedure Code Range	90832	90834	90837
Your Billing Distribution[1]	[redacted]		
Your Billing Distribution %			
Expected Billing Distribution %[2]			



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-Psychotherapy times are for face-to-face services with the patient and/or family member.
-The patient must be present for all or some of the service.
-In reporting, choose the code closest to the actual time (i.e., 53 or more minutes for 90837); some carriers may require documented start and end times.
-Documentation supporting medical necessity.

Footnotes

1. Data represents claim paid dates from 10/1/2021 to 12/31/2021 where psychotherapy codes 90832, 90834, 90837 were reported.
2. Expected Billing Distribution represents average distribution of psychotherapy codes billed by providers within the same specialty.

[redacted]

Claim Rejected By Clearinghouse

- **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 844-592-7009 OPTION 3.**