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December 8, 2015

Via Electronic Mail to Blake.Webber@mahouse.gov

Dear Chairman Eldridge and Chairman Michlewitz and distinguished members of the Joint Committee on Financial Services,

Thank you for the opportunity to testify in support of House Bill 925, An Act to Limit Retroactive Denials of Health Insurance Claims for Mental Health and Substance Abuse Services, filed by Representative Jim O'Day.

We are CliniciansUNITED (CU), a multidisciplinary group of independent mental health clinicians in Massachusetts that are associate members of SEIU Local 509. CU supports passing House Bill 925. We believe that regulating the current auditing practices insurance companies use for services already approved and rendered is long overdue.

The way it works now is that health care providers, including mental health clinicians, are required to meet billing deadlines (usually 60 or 90 days) and get prior authorization or approval before providing services (or within 24 hours) in order to receive payment from insurance companies.

However, no such timeline exists for insurance companies to prevent them from recouping payment from providers for services delivered after the fact. An insurance company can, for almost any reason, come back and demand to see a clinician's files -- we're talking a full-scale audit of paperwork, case files, even notes taken during therapy sessions. And if any "i" isn't dotted or "t" is left uncrossed, they can use that minute detail to retroactively deny that course of treatment and demand a clinician return payments made for an individual session or even a series of treatments over time. You will hear stories that illustrate that point -- and I have also included more in our written testimony, but I also wanted to share some background to frame the scope of the issue.

A recent survey by the UMass Donahue Institute shows that 10% of the clinicians surveyed who have been audited in the past five years were asked to return money that had already been reimbursed. And we are not talking about just small amounts of money either. Two-thirds of clinicians who have faced these so-called "clawback" from insurance companies have paid more than $1,000 per occurrence and several have paid up to $30,000. Although audits do not always result in a clawback, these clinicians are small businesses. When you have a small business that operates on a very slim margin these clawbacks in the thousands of dollars, can make the difference between serving clients in the community and folding up shop.

I would like to share a story of a clinician in Massachusetts who is facing this issue, in her own words:

"I am a Licensed Mental Health Counselor in private practice. My clawback situation is that an insurance company expects me to pay back $27,000. Their rationale for this demand comes from their legal

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department and is based on a "documentation audit". I complied with the audit request by sending my notes and files on the 21 clients going back to 2012 that they requested, believing that everything would be fine. However they found my documentation did not meet the standards of the American Association of Professional Coders. I pointed out in my reply that I am not a professional coder and that my notes met the standard for my professional association (Massachusetts Mental Health Counselors Association). Furthermore in no communication to me, nor was there any mention on the insurance company's website, were the American Association of Professional Coder's standards stated and the expectation that these standards should supersede my professional organization's standards made explicit.

Another issue was seeing clients twice a week and the legal department's determination that the notes did not support the need to see the patient twice a week. In one case I had been seeing a child over 34 weeks who was very anxious, was dealing with a high conflict divorce, sleep problems, depression, suicidal thoughts and school refusal. I was working with the school and both sets of parents to encourage the child to attend school with some success. Each eight sessions from the insurance company needs to be approved and the method for doing this is to submit online the severity of the situation and an update on symptoms using their format. The legal department said there was insufficient documentation to support seeing this client twice a week and therefore wanted the money back for 34 sessions. I pointed out that in fact the insurance company knew about two sessions per week via the approval process for sessions and my billing, and to come back to me after a year's time from termination and tell me that it was insufficient documentation was ridiculous. If there was insufficient documentation when applying for the sessions, then why did the insurance company approve additional sessions based on the acuity and symptom information I provided? Their response to this was that the clinical team had approved, but that the legal department now was finding my documentation wanting. All sessions had dates and notes associated with those visits.

The above are just a couple of the issues that they identified as documentation issues. There were no complaints from any of my clients, treatment for most if not all had been successful and concluded or at least become less frequent, and I can honestly say that I provided very good service to these clients. To be told that my documentation was insufficient and that I need to pay $27,000 back to the insurance company demonstrates how the insurance company has all of the power in the situation and the clinician has very little."

This clinician adhered to all of the timely filing standards required by insurance company, received authorization to see clients from the insurance company, and provided care to her clients. Three years later, she receives a letter in the mail that she must pay back $27,000 for work she has already done and had been approved by the insurance company. If House Bill 925 was law, the audit would have been completed within 6 months of her reimbursement claim and hopefully it would have helped these issues come to light earlier -- rather than three years later.

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When we talk about the factors that drive down access to mental health care in Massachusetts we need look no further than the practices of the very entities our parity laws were designed to combat to begin with. These are far more subtle and less detectable means to retroactively deny critical care. They may not violate the letter of our parity laws, but they certainly violate the spirit of the laws -- every single day.

We understand that insurance companies need to have checks and balances to make sure fraudulent reimbursements are not being issued. However, the current system is heavily weighted toward the insurance company and includes a ridiculous double standard. The insurance companies may say that a clinician can file an appeal or that they have advocacy avenues within the Department of Insurance, but that is ignoring the heart of the issue. This is about leveling the playing field to acknowledge that clinicians deserve to have the same standards that they adhere to when working with insurance companies. This legislation will hold insurers accountable to the intent of our legal standards -- standards that were established to guarantee equal access to mental health care.

Many other states have passed legislation that addresses this issue and limits the time insurance companies have to conduct these audits. Massachusetts needs to join these other states in regulating this grossly unfair business practice. We hope that this committee acts to pass this critical piece of legislation. Thank you again for the opportunity to testify today and I urge you to report this bill favorably.

Sincerely,
Julie Balasalle
Organizer, CliniciansUNITED

SUSAN TOUSIGNANT ISRAEL PIERRE CHRISTINE CREAN