The Coalition

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February 2004

Advocates for Ethical Mental Health Care

Editor's Corner:

Peter N. Moore, Psy.D.

We lead this issue with breaking news! As you will read in our headline article, the *DOH* has backed off a potentially Draconian measure that would have further threatened the sanctity of our records. Thanks to our lobbyist, Laura Groshong, and others in the mental health community, we have succeeded in stopping a proposal that would have given DOH unprecedented power to seize mental health records without prior notice. This is yet another way your dues work for you. Please renew and encourage others to join us.

Part of this issue takes a little different tack. Generally, we strive to inform you of the Board's work, Laura's efforts in the legislature, and other events concerning managed care, insurance and issues affecting privacy, confidentiality, and choice. Our major focus has been on private practice because of the nature of our membership. However, issues of access also affect the *public sector* and recent developments in DC could seriously limit the extent to which society's disadvantaged can access mental health care. I outline those threats to service and what their implications for us all.

Medicare has begun to audit psychologists in other parts of the country. Laura Groshong, our lobbyist has been on top of developments and she has sent us important information to head trouble off at the pass.

Finally, some more good news for mental professionals. See the story about *Oxford Health Plan* on page five.

Who Ya Gonna Call !?!?!??!

Coalition Helpline: 206-444-4304

Who's My Legislator: 1-800-448-4881 (State and Federal)

Legislative Hotline: 1-100-562-6000

Battle to Protect Mental Health Records

Laura Groshong, WSCMHPC Lobbyist

The Department of Health has submitted a bill, HB 2879, which would require all licensees to be subject to copying of their records without adjudication if an investigator.suspects fraud. While this represents a threat to a clinician's right to due process, it is an improvement over the original wording that would have allowed our computer hard drives to be seized.

Currently, a licensee has 14 days to produce relevant records when charges have been filed, 20 days to request a judicial hearing before giving over records, and, if requested, 60 days to prepare for the judicial hearing. Investigators maintain that this gives licensees too long to change records so that the they are more favorable to the licensee. DOH investigators feel that licensees, in addition to possibly altering records, seek legal counsel more often before handing over records, which interferes with the investigators' access to our information.

I am working with a group of mental health lobbyists to oppose this bill and we hope to have it amended to maintain the rights of clinicians to due process. I would like to take this opportunity to thank the outstanding group of mental health lobbyists I work with in Olympia and without whom I could not accomplish the legislative achievements we have all contributed to. Additionally, Gail McGaffick, Lucy Homans, Lonnie Johns-Brown, Nick Federici, Melanie Stewart, Kirsten Rogers, Seth Dawson, and Terry Kohl, provide invaluable assistance.

Public Mental Health Facing Cuts: Why We Should Care

Peter N. Moore, Psy.D

Most of you who peruse this periodical no doubt are doing well just to keep track of your own business and may give only a passing glance that time permits to policies that affect the poor. If you are like me, you may have only some vague notion of how low income folks get their mental health needs addressed. Changes are occurring and while they may not affect our individual practices, they will affect our quality of life.

The Coalition learned of these changes from Cathy Gaylord, the CEO of the Washington Community Mental Health Council. The Council, founded over 25 years ago, is an advocate for the indigent. It, like the Coalition, lobbies the legislature and state agencies. Ms Gaylord warned that in the Balanced Budget Act of 1997 lurk provisions that will significantly affect the impoverished's ability to access mental health benefits. Sound familiar?

First, a little background for the uninitiated. Public mental health services are divided into 14 "Regional Support Networks" (RSN's) in this state. They act as intermediaries between state regulatory agencies and the mental health professionals in the trenches who serve the poor. The agencies were established in an attempt to decentralize decisions about how the state allocates resources for the poor.

For a number of years, public mental health services have been managed. But, RSN's were exempt from having to comply with laws and regulations governing management of services with which the major insurance companies have had to follow. Therefore, they did not have to submit the quantity of paperwork showing quality assurance and improvement. However new regulations

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Eds. Note: Laura Groshong, our lobbyist passed along the following information noting that while this did not apply to Washington, "it is important to be aware of what Medicare expects."

Widespread Psychotherapy Audit by Medicare of CPT 90816

DC/DE, MD, TX, VA, IHS Service Areas

Medicare recently conducted a service-specific widespread probe for psychotherapy services. Clinical psychologists were selected for review because the data analysis indicated that their billing pattern for Current Procedural Terminology (CPT) procedure code **90816** (individual psychotherapy, 20-30 minutes face-to-face with the patient) was at least three standard deviations above the mean based on claims paid between June 2002 and November 2002.

Follow-up to the widespread psychotherapy probe included notification to each participant of their individualized findings and publication of this article to inform the provider community of the probe findings and helpful documentation guidelines.

Overall, the major findings identified in the widespread psychotherapy probe review are listed below:

Lack of documentation indicating why individual psychotherapy was the appropriate therapy treatment modality for each individual patient, either in lieu of or in addition to another form of psychiatric treatment.

Lack of documentation indicating how the treatment improved the patient's health status or stabilization of function for an acute problem or chronic problem, or a description of each patient's capacity to participate in and benefit from

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proposed by the Bush administration want RSN's to act more like private commercial plans. They will have to provide more paperwork but without more resources because this mandate is unfunded. As much as an irritant this may be to the people who provide and administer services, clients will not feel any direct impact, Ms Gaylord reports.

However, other changes may dramatically limit who can receive treatment. Currently, if someone is on Medicaid, federal moneys pay for half of the cost while state funds pay the other half. Someone not on Medicaid would technically be out of luck, but Ms Gaylord, noted, a "lenient" federal policy allows RSN's to use any unspent Medicaid money to treat non-Medicaid patients and for budget planning.

Here is where the Budget Balanced Act of 1997 comes into play. Although enacted several years ago, the regulations can take awhile to implement, and with new faces in Washington, new interpretations will bring changes. So, say good-bye to "lenient" interpretation. The Bush administration wants to require an actuarial study every two years to determine how money is spent. The study will only count Medicaid money that is spent and not funds used on people outside of the Medicaid system. Therefore, the "left over" money that was spent on non-Medicaid clients may no longer be used to determine future funding for mental health services. Consequently, public agencies have no incentive to treat the poor who are not in that system.

And who are those folks? According to Ms Gaylord, they represent 30% to 40% of public mental health consumers. They are people too disabled to apply, the homeless who do not have an address or telephone, the working poor, and people whom the Department of Disability Determination Services have denied disability payments.

Ms Gaylord reported that each RSN would have to decide how it would handle the problem. The

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psychotherapy.

Lack of correct documentation of current provider address, telephone number and practice association for the billing Medicare provider in the Provider Enrollment department.

Lack of documentation of providers submitting incomplete or incorrect documentation to support the reviewed service.

The following information is to aid providers with appropriate documentation of the CPT service billed with code 90816. This information is not conclusive. Additional guideline information, requirements and resources are available at: http://www.trailblazerhealth.com. At this site, providers can access previously published Medicare newsletters and local medical review current policies, as well as proposed medical review policies.

Medical Record Documentation

1) The medical record must indicate the **time spent** in the psychotherapy encounter and the therapeutic maneuvers performed, including behavior modification, supportive interactions, and interpretation of unconscious motivation that was applied to produce therapeutic change.
2) The medical record should document the **target symptoms, the goals of therapy and the methods** used to monitoring the documented outcome(s).
3) The medical record should document why the **chosen therapy is the appropriate treatment modality** either in lieu of, or in addition to, another form of psychiatric treatment.
4) The medical record must indicate the **medical necessity of the chosen treatment/testing** in the patient's medical record by the treating provider.
5) The medical record should contain the **patient's capacity to participate in and**

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benefit from psychotherapy.
6) The medical record should contain the **duration of treatment** in specific number of sessions.
7) The medical record for an acute problem should include **what treatment improvement is expected** in the patient's health status or function.
8) The medical record for a chronic problem should include **what treatment stabilizes or maintains** the health status or function that is expected.

This CPT code, 90816, should not be used as a generic psychiatric service code.
Documentation for a patient in a nursing facility must contain the attending physician's evaluation of the patient and an order of authorization for a service, procedure or referral of the patient to another provider specialty. If the patient, family member or legal guardian authorizes an order for a service specialty or procedure, the attending physician must be notified of the change in the patient's physical, mental or psychosocial status, or the need to alter the patient's treatment significantly. The medical necessity for and the nature of each service or procedure must be clearly documented by a physician, and this physician's authorization of the order for the service, procedure, or referral to another provider specialty must be clearly documented in the patient's medical record.

All documentation must contain the patient's individualized medical necessity and the provider's individual services rendered to meet each of the patient's individual medical needs. Corrective actions that have or will take place because of the widespread probe review include the following:
1) Sending individual education letters addressing the identified documentation and billing issues.
2) The collection of overpayments by our Overpayment department mailed separately with instructions on the provider's overpayment protest rights, and instructions for protest submissions.
3) Periodic re-evaluation of psychotherapy services via statistical data analysis. Should a continued or new concern be identified, additional contractor actions may be necessary. These may include another probe review, the initiation of prepayment review monitoring for specific providers, providers referred to Medicare's Program Safeguard Contractor, and/or referral to CMS.

Help The National Coalition Protect Privacy

The National Coalition of Mental Health Professionals and Consumers has joined a lawsuit with the American Psychoanalytic Association (APsA), to take up the HHS changes that watered down HIPAA standards in 2002. This suit would force HHS to abide by the original intent of the law that would require patient consent **before** disclosures are made. The suit maintains that late changes proposed by the Bush administration significantly weaken protection from access. The costs of this suit against the government are enormous and the issue is one all of us should be deeply concerned about. We ask you to support this courageous fight and do whatever you can to help financially. You can make donations through the National Coalition Website at www.TheNationalCoalition.org. All of the Board and Committee members of the National Coalition are volunteers. They have only one paid employee. All donations will be used to support the lawsuit or other designated Coalition activities.

THANKS FOR SUPPORTING

THE COALITION !!!

Score One for Us

Peter N. Moore, Psy.D.

In a story with implications for those of us accepting insurance payments, The *New York Times* reported in November that Oxford Health Plans (OHP) has backed away from an attempt to force some New York state psychotherapists to refund their payments.

OHP, while not in our area in any significant way, nevertheless serves "more than 1.5 million members" and has "audited the billing of 300 psychiatrists, psychologists, and social workers dating to 1997." Based on their audits, they then "demanded" that about 80 mental health professionals reimburse them.

The article notes that Oxford, after examining a sample of session notes, wanted at least partial refunds because the notes "reflected only 20 or 30 minutes of a 45 minutes session or from psychiatrists who billed for medication in addition to psychotherapy but did not name the medication. Oxford assumed that the same transgressions applied to all cases after sampling a few. The article said that "many therapists" complained that they could not get Oxford to clarify what if any standards it was applying for the billing challenges.

Part of the problem may have stemmed from therapists making "only the barest of session notes to protect client privacy." A company spokesman said that the audits revealed "not widespread attempts to inflate the bills" but "'a significant variability in how people approached documentation."

The New York State Psychological Association, while hailing the "victory" still wanted more concessions from Oxford.

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Spokane area for example, she said, has cut non-Medicaid clientele to 2%. King County will not see much change. Suspicious of the leniency interpretation, it cut "severely" the delivery of mental health services.

So as unfortunate as this is to the people who valiantly deliver services and those who will not be able to benefit from them, what is the impact to the rest of us? Ms Gaylord predicts that jails will see an increase in the number of people brought to them for involuntary commitment because state hospitals will have less room. She also forecasts that the increasing number of people with untreated mental health problems will result in more crime and therefore a greater drain on already overtaxed law-enforcement agencies. Further, she suggests, that those people who may have been able to work will not be able to do so because they will lack the support of mental health treatment. Unemployed, they will also drain public moneys.

With a lot less money going from federal to state coffers and with the current anti-government and anti-tax sentiment amongst the voters who show up at the polls, the indigent and financially marginal in our system who are vulnerable to mental health issues will face even greater challenges in the years ahead if these changes are implemented. The rest of us may experience the gradual degradation of our quality of life, slower or less government service, less police protection, or even the increased risk of being a crime victim.

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