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Submitter:	Tiffany Kettermann
On behalf of:	Health Allies Counseling
Committee:	House Committee on Behavioral Health
Measure:	HB 4028

Dear Chair Pham, Co-Chairs Edwards and Javadi and Members of the Committee,

My name is Tiffany Kettermann. I am a Licensed Professional Counselor and the owner of Health Allies Counseling, a group practice with 48 staff serving nearly 900 clients in Portland, over half of which are Medicaid. I am also an original co-author of HB 4028. Protecting provider rights, preserving access to care, and advocating for fair audit practices has been my passion for over a decade. This bill reflects years of advocacy on behalf of many providers, as well as my own lived experience.

I have shared my personal experience with insurance audits in prior testimony, including testimony submitted in support of HB 2455, and I refer the Committee to that record. In brief, I have personally experienced multiple audits as both a solo and group provider, and every provision of this bill is informed by those experiences. Today, I write to build upon that testimony by responding directly to letters submitted in opposition to this legislation.

As context for this response, I have attached a copy of a mental health provider audit that is currently being widely circulated within our professional community. Although this audit involves an out-of-state provider, it contains all of the elements I have personally witnessed in many local audits and accurately reflects what has become a sadly typical experience for mental health providers.
I ask the Committee to review this audit carefully. In December 2025, the provider was given 20 days to repay $551,000 to a major commercial insurer. The cited “errors” included documenting appointment times based on calendar scheduling rather than recorded time-in and time-out, and noting that sessions were conducted via teletherapy without specifying that they occurred by video. Just one encounter – one note - in the audit was not a technical issue.

Based on these technical documentation issues, approximately $12,000 in questioned claims was extrapolated to a 100 percent error rate across 140 reviewed records. As a result, the insurer demanded repayment of $551,000 in 20 days time. This letter was written two months ago.

This type of extrapolation based on minor, non-fraudulent documentation discrepancies is profoundly familiar to providers practicing in Oregon. It reflects the systemic imbalance that HB 4028 is intended to address.

Insurance companies hold enormous power in the audit process. They write the rules, interpret the rules, change the rules, and enforce them with little meaningful oversight. With the rapid expansion of AI-driven audits, this power is increasing at an unprecedented pace. Insurers can now review thousands of records at once and generate large-scale clawbacks with the push of a button.

By contrast, the only meaningful power many therapists currently have is to stop accepting insurance – or leave the field altogether. And that is what they have been doing in increasing numbers. HB 4028 provides a framework to begin restoring balance. It preserves accountability while helping to prevent financial devastation over minor, non-fraudulent errors. It promotes transparency that does not currently exist in the audit process. It encourages education instead of punishment. Most importantly, it allows therapists to focus on their clients rather than living in constant fear of retroactive enforcement and financial devastation.

I have attached my responses to the opposing testimony below for your consideration, as well as the aforementioned December 2025 audit letter.

I remain committed to collaborative problem-solving. However, many proposed amendments would preserve the existing imbalance of power and the very practices that have caused widespread provider harm. HB 4028 represents a carefully calibrated response that promotes accountability, transparency, and sustainability.

For these reasons, I respectfully urge the Committee to support HB 4028.

Thank you for your time, thoughtful consideration, and continued commitment to behavioral health access in Oregon.

Sincerely,

Tiffany Kettermann, LPC, LMHC, MPA, MA
Owner, Health Allies Counseling
Co-Author, HB 4028

Attachment: Responses to opposing testimony

Notice of Contract and Rule Changes (Section 4(3))

With respect to Section 4(3), the 30-day notice provision establishes a reasonable expectation of transparency when documentation standards or contract terms change. Providers cannot comply with rules that are altered without notice. Advance notice promotes compliance, reduces disputes, and supports network stability. This provision does not prevent implementation of urgent federal or court-mandated changes; rather, it establishes a baseline expectation of good-faith communication.

Audit Timelines (Section 4(5))

Regarding Section 4(5), fixed timelines are a standard feature of audit systems across healthcare. They exist precisely because open-ended reviews create prolonged uncertainty, financial instability, and pressure to settle inaccurate findings. Providers already have strong incentives to cooperate promptly, and delays harm providers financially and professionally. Allowing the audit clock to reset based on successive document requests would enable indefinite reviews and undermine the purpose of having any deadline.

Revised Audits (Section 4(6)(b))

Section 4(6)(b)'s "reason to believe" standard reflects a recognized legal threshold that appropriately balances efficiency and accuracy. It does not permit speculative or frivolous requests. Providers must still identify specific legal errors, submit documentation, and participate in formal review. This provision creates a mechanism to correct mistakes before litigation becomes necessary, reducing administrative burden for all parties.

Audit Lookback Period

With respect to the audit lookback period, HB 4028 aligns Oregon with common national practice. Many states and payers limit routine Medicaid or managed care audits to three to five years absent fraud. For example, California's Medi-Cal program generally applies a three-year lookback period, Texas Medicaid audits are commonly limited to three to five years, and New York Medicaid audits typically operate within a three- to six-year range depending on circumstances. Commercial insurers nationwide frequently limit reviews to two to four years. A five-year standard reflects a balanced approach between program integrity and administrative burden.

Federal overpayment regulations govern reporting obligations once overpayments are identified; they do not mandate audit lookback length. Importantly, HB 4028 preserves extended review authority in cases of fraud or improper payment, ensuring continued program integrity and compliance with federal law.

Guidance and Transparency

Letters submitted in opposition suggest that existing manuals, portals, and internal policies provide sufficient guidance. This assertion does not reflect the experience of providers in practice, and I respectfully invite those who oppose HB 4028 to identify the specific materials they believe provide this guidance.

In reality, the materials that exist do not teach therapists how to create documentation that meets audit standards. They are general policy manuals written primarily to protect insurance companies' legal and financial interests, not to guide clinicians in how their notes will be evaluated.

In prior legislative sessions, opponents have also pointed to provider representative departments as a source of support. In practice, most major insurance companies have eliminated these departments entirely. For many providers, there is now no designated representative to contact for clarification, guidance, or feedback. Requests for assistance are often routed to generic portals or automated systems that provide no meaningful support.

As a result, providers are left without any reliable avenue for obtaining clear, practical instruction. Many do not learn what is considered compliant documentation until after an audit is underway. Written policies alone do not constitute functional transparency. HB 4028 addresses this gap by establishing clear procedural expectations and promoting meaningful, actionable guidance before enforcement occurs.

Claims Processing and System Limitations

Those who oppose HB 4028 have raised concerns regarding claims processing systems and the ability to differentiate between provider sizes. HB 4028 is not intended to interfere with routine, real-time claims adjudication or automated correction of obvious submission errors. The bill is focused on insurer-initiated, post-payment audits and retroactive recoupments that result in substantial financial clawbacks months or years after services are delivered. Routine administrative corrections are fundamentally different from retrospective enforcement actions.
If additional clarification is helpful, it can be addressed through targeted rulemaking or technical guidance without weakening the bill's core protections. System limitations should not justify continued exposure of small providers to disproportionate financial harm.

Mental Health Parity and Medical Management

Opponents of HB 4028 have raised concerns regarding Mental Health Parity reporting and medical management provisions. These sections reflect how access to behavioral health care is regulated in practice through utilization review, documentation standards, and authorization requirements. Transparency in these areas strengthens parity enforcement by ensuring that oversight reflects actual

operational practices. These provisions do not expand parity law beyond its intent; they support its effective implementation.

Medical Policy Transparency

With respect to medical policy disclosures, HB 4028 does not require carriers to violate contractual or intellectual property restrictions. Rather, it seeks reasonable transparency regarding the standards governing authorization, coverage, and payment decisions. Where third-party tools are used, providers must have meaningful access to the governing criteria. Where proprietary limitations exist, implementation mechanisms can be developed that preserve contractual obligations while meeting transparency objectives.

System Impact and Network Stability

Those who oppose HB 4028 further express concern that Section 4 will strain resources and disrupt payments. In practice, current audit practices drive providers out of networks, increase administrative conflict, and destabilize care delivery. Clear timelines, transparent standards, and meaningful review processes reduce appeals, litigation, and provider turnover. These reforms strengthen—not weaken—the Medicaid delivery system.

Stable provider networks benefit coordinated care organizations, the Oregon Health Authority, and Medicaid members. When providers leave networks, patients delay care or go untreated, and long-term system costs rise. HB 4028 helps prevent this outcome by supporting ethical, experienced providers in remaining in-network.

Fiscal Context

Some opponents have suggested that current fiscal pressures make this an inappropriate time for reform. In reality, periods of financial strain make stability more important, not less. HB 4028 does not increase reimbursement rates or weaken oversight. It protects network continuity at a time when provider retention is already under threat.

advize

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

January 13, 2026

[redacted]

Re: APPEAL of Claims Overpayment Determination — Case No. BlueCross BlueShield Arizona - 20250822-27403 (AZBlue)

Dear Provider,

We are reaching out on behalf of BlueCross BlueShield Arizona regarding the claim's overpayment determination issued on December 1, 2025. We received your "**Request for Reconsideration of Recoupment Demand**" letter dated December 5, 2025. We reviewed your dispute and **all** documentation initially submitted (*before the appeal deadline*) as well as the **additional** documentation you specifically requested be submitted for consideration on **December 19, 2025**, (*after the appeal deadline*) and uploaded to the Advize Health, LLC SharePoint on **December 21, 2025**.

The dates of service for this audit were September 26, 2022, through September 26, 2025. In your email (*dated Friday, December 19, 2025, at 8:37 AM*), you questioned dates of service that fall outside a "one-year look-back period" and requested confirmation the older dates of service are being excluded from the scope of this review.

My response to your email (*dated Friday, December 19, 2025, at 2:54 PM*) was the BlueCross BlueShield Arizona Fraud and Abuse website states the plan's special investigations unit is dedicated to investigating suspected fraud, waste and abuse. Our investigations are based on data mining and analysis of provider claims. We request medical records to substantiate the claims billed. We follow the Centers for Medicare & Medicaid Services (CMS) guidelines for fraud, waste and abuse look back periods which can be three (3) to six (6) years. Therefore, the dates of service range for your medical records were appropriate for inclusion in the statistically valid random sample requested.

Based on our audit findings of your APPEAL documentation, the total overpaid amount due to BlueCross BlueShield Arizona within 20 calendar days of the date of this letter is $551,079.33.

How and why was this determination made?
On behalf of BlueCross BlueShield Arizona, Advize Health, LLC, regularly reviews paid claims to verify consistency with coding and billing requirements and help ensure all charges are properly supported.

As part of our review, we consider applicable BlueCross BlueShield Arizona reimbursement policies, American Medical Association (AMA) CPT guidelines and the BlueCross BlueShield Arizona Provider Operating Guide.

Following a thorough review of this information, we determined:

- One hundred and forty (**140**) total claim lines were reviewed on **APPEAL**.

- There was a **97%** error rate.
- Of the **140** total claim lines of the **APPEAL** reviewed:
  - Four (**4**) claim lines were determined to be **SUPPORTED** by the documentation submitted in support of the claim(s) billed.
  - One hundred and thirty-six (**136**) claim lines were determined to be **UNSUPPORTED** by the documentation submitted in support of the claim(s) billed.

The following are specifics regarding the variances found:

- Session Timing Issues
  - Documentation for multiple encounters does not include the start and end times for the session.
    - The time recorded reflects the scheduled appointment rather than the actual time spent with the patient.
  - CPT 90837 requires a minimum of 53 minutes to have been spent and to be documented to justify billing psychotherapy at that level.
- Provider Billing Discrepancy
  - Documentation for one encounter indicates the session was not rendered by [redacted], PsyD. The patient was actually seen by [redacted] PsyD.
  - [redacted], PsyD, must submit claims under their own NPI as the licensed provider rendering the service. Billing under another provider's NPI is not supported by documentation and does not comply with billing regulations.
- Telehealth Documentation
  - The documentation for every telehealth encounter does not clearly indicate whether telehealth services were conducted via video. This should be explicitly stated in the record to meet telehealth compliance requirements.
- Incident-to Billing
  - The services billed as incident-to are denied because there is no documentation supporting physician initiation of the plan of care, continued involvement in the patient's care, or direct supervision of the services, and therefore do not meet CMS' requirements for incident-to billing.

The following additional resources and supportive guidelines were used in making our audit determinations:

- Current Procedural Terminology ®
- AMA Evaluation and Management (E/M) Services Guidelines
  - https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
- https://www.azblue.com/provider/resources
- AZ Blue Provider Operating Guide

As a result, you must refund the amount(s) overpaid no later than 20 calendar days from the date of this letter.

Summary of extrapolated claims

Procedure code(s)	Total universe payment	Number in sample	Number of errors in sample	Total sample reviewed payment	Total sample payment unsupported	% Error	Extrapolated[1] overpayment
90791	$29,259.22	5	5	$703.33	$703.33	100%	$20,260.27

[1] Extrapolation performed via RAT-STATS, a statistical application written for and maintained by the Office of Inspector General (OIG) for the Department of Health and Human Services (DHHS).

90837	$550,093.45	126	122	$11,614.34	$10,969.64	97%	$494,350.57
90847	$30,990.14	9	9	$645.21	$645.21	100%	$36,468.49
Grand Total	**$610,342.81**	**140**	**136**	**$12,962.88**	**$12,318.18**	**Grand Total**	**$551,079.33**

How can I refund this overpayment?
Please send a check or money order payable to BlueCross BlueShield Arizona for **$551,079.33** (*the overpaid amount*). Include a copy of this letter with your payment. The repayment must be received by BlueCross BlueShield Arizona within **20 calendar days** of the date of this letter. Send the repayment to:

BlueCross BlueShield Arizona
Attention: SIU
PO Box 35722
Phoenix, AZ 85069-5722

What happens if I don't respond?
If an overpayment refund is not timely received, applicable laws permit us to proceed to "offset" or deduct amounts owed from future claim payments. In the event of an offset, we will adjust the claim to reflect the overpayment and send you a corrected provider remittance advice (PRA).

If you do not agree with the claim adjustment once it has been made, the next step in addressing your concern is to submit a claim reconsideration request as outlined in the PRA. Please do not submit a claim reconsideration request before the adjustment has been made.

Questions?
If you would like more specific information regarding the overpaid claims noted above, please contact Mark Porter-Rodriguez at (214) 716-8588 or email mark.porter@azblue.com between 8 a.m.– 4 p.m. CST, Monday–Friday.

Sincerely,

Mark Porter-Rodriguez

Mark Porter-Rodriguez
Investigator
Advize Health, LLC
on behalf of BlueCross BlueShield Arizona

Protecting patient privacy
As outlined in the Health Insurance Portability and Accountability Act (HIPAA), Advize has entered into a business associate agreement with BlueCross BlueShield Arizona. This means it can request medical records without additional patient authorization as a business associate for the purposes of payment activities.