Stacy Brenner
Senator, District 30

THE MAINE SENATE
131st Legislature

3 State House Station
Augusta, Maine 04333

Testimony of Senator Stacy Brenner introducing *LD 1383, "An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services"*
Before the Joint Standing Committee on Health Coverage, Insurance and Financial Services
April 13, 2023

Senator Bailey, Representative Perry, and Distinguished Colleagues on the Joint Standing Committee on Health Coverage, Insurance and Financial Services, my name is Stacy Brenner. I represent Senate District 30, which includes all of Gorham and most of Scarborough. I am pleased to introduce *LD 1383, "An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services."* This legislation will address the growing problems rehab providers are having in Maine and nationwide with insurance carriers' use of administratively burdensome and clinically unnecessary prior authorization.

Carriers will tell you that they require prior authorization to ensure that the services provided are medically necessary. For physical and occupational therapy services, the "medical necessity" review is done on an online platform using an artificial intelligence algorithm that arbitrarily approves only a small number of visits without regard to the patient's diagnosis, comorbidities or the number of visits required by the treatment plan. This is not a medical necessity review. These algorithms are widely known to be arbitrary and capricious. They are built to approve a smaller number of visits, while requiring more paperwork for each additional request for more visits. In some cases, the provider and patient become frustrated by this system, to the extent that they give up on the plan of care all together. This result can be detrimental – especially to post-op patients – resulting in patients needing more expensive treatment interventions and surgeries later.

For instance, Anthem's utilization review entity, "AIM", now known as "Carelon," does not let the therapist enter the number of visits needed in the Plan of Care. It routinely approves 4 to 6 visits on the first request, 2 to 4 visits on the second request and 1 to 2 visits for each request thereafter. The first 2 requests take about 30 minutes to process, then each subsequent request takes up to an hour. These requests take more time when the therapist has to make phone calls, do a peer-to-peer consult or when the platform malfunctions, which is a common occurance. This system of prior authorization also adds at least 20% more to the cost of providing care. It is threatening the viability of small private practices who have not had an increase in reimbursement in over 15 years. It is also the reason new therapy practices are staying out of network entirely.

Aside from pediatric patients, most patients conclude their Plan of Care within 12 visits, which typically consists of 2 to 3 hour-long visits per week for 4 to 6 weeks. This is the number of visits that Anthem routinely auto-approves. However, these 12 visits necessitate 3 to 4 prior authorizations and 2 to 3 hours of administrative time since Anthem started requiring prior

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authorization in 2019. The therapist also has to take 15 to 30 minutes out of the patient's treatment session to take measurements that the platform requires – measurements that are frequently irrelevant to any medical necessity decision. Now, 12 visits require 14 to 15 hours of work for the provider and 1 to 2 hours less of treatment for the patient.

Essentially, the carrier is requiring hours of additional work when they automatically and routinely approve 8 to 12 visits. LD 1383 will fix this problem by prohibiting prior authorization for the first 12 visits.

Frequent prior authorization requirements also create interruptions and delays in patient care and high levels of uncertainty for providers and patients. Visits are frequently cancelled because of the time it takes to submit the request and subsequently receive an answer. Patients never know from one week to the next whether they are able to carry out their plan of care or if their plan will be interrupted by inappropriate denials - necessitating appeals that cause more administrative burdens and treatment delays.

In April 2022, the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services published a report on the use of prior authorization by Medicare Advantage Organizations (MAOs). OIG indicated that the use of prior authorization frequently caused delays in the beneficiary's access to medically necessary services and denial of payments to providers for covered services that should have been paid.

LD 1383 would fix the delays and interruptions in care by requiring a 24-hour turnaround for requests for additional visits. The Affordable Care Act already requires carriers to answer any request to extend a course of treatment that is already in progress, within 24 hours. In addition, the Centers for Medicare and Medicaid Services (CMS) recently published proposed rules for prior authorization procedures for Medicare Advantage Plans that will require shorter time frames for prior authorization decisions. In Congress, Rep. DelBene of Washington is sponsoring bipartisan legislation to further regulate prior authorization, *H.R. 3173, "Improving Seniors' Timely Access to Care Act of 2022,"* which will require real-time decision-making on prior authorization requests. This legislation was passed in the House and will be voted on in the Senate, showing support at the federal level. Therefore, carriers should be able to meet this requirement of shorter time frames for requests when it is already mandated and continues to be further regulated under federal law.

LD 1383 would also require carriers to approve a minimum of 6 visits at a time when a patient needs more than 12 visits, rather than only 1 to 2. When only 1-2 visits at a time are approved, the cost to provide the care almost doubles and the patient's improvement is too small to be measurable.

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6 visits allows enough time and treatment for the patient to make measurable improvement, which carriers require in order to justify the medical necessity of ongoing care.

To address the needs of chronic pain patients who routinely need more care, this bill prohibits requiring prior authorization for therapy services for the first 90 days of treatment. This ensures that chronic pain patients have adequate access to conservative, non-pharmacologic treatment without ongoing interruptions in their care by unnecessary prior authorization. This should not be misinterpreted to mean that every patient with chronic pain automatically gets 90 days of therapy whether they need it or not.

It is important to note that this bill doesn't entitle patients to services or a providers to pay for services that are not medically necessary. Carriers always have the right to review medical records for medical necessity before paying a claim. They can also retroactively reimburse money for claims that were not medically necessary on a post-service review. In these cases, Maine law requires that the patient be held harmless from having to pay the claims. The intention of this legislation is not to encourage therapists to provide services that are not medically necessary. If they do, they risk not being paid.

We welcome the opportunity to work with interested parties on this bill to make sure it addresses the needs of patients and providers without interfering with the carriers' use of reasonable utilization review procedures where they are necessary.

Thank you for your time and consideration. I would be happy to answer any questions.

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