

Testimony in Support of LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services

HCIFS Committee, April 13, 2023

Senator Bailey, Representative Perry and Honorable Members of the HCIFS Committee:

My name is Gwen Simons. I am a physical therapist and a healthcare lawyer in Scarborough. I'm testifying as the lobbyist for the Maine Chapter of the American Physical Therapy Association ("MEAPTA") in support of LD 1383. I want to thank Senator Stacy Brenner for agreeing to bring this important bill forward and our bipartisan list of sponsors.

First, I want to say that we are bringing this issue to you as a last resort and an emergency. We've worked with local carriers in the past to address our concerns about the algorithms that utilization review entities are using to make medical necessity decisions with some limited success. We have not had any luck with Anthem. Since Anthem is the largest carrier in Maine, their policies have tremendous impact on Maine providers and patients, so we need your help.

History of the problem in Maine. This problem started circa 2011, when CIGNA started using a utilization management company called Orthonet for PT and OT prior authorization. Their pattern was to arbitrarily approve, 6, then 4, then 2, then 1 visits at a time then deny all further visits. CIGNA had a small market share in Maine at that time, so many Maine PT providers dropped out of CIGNA's network. CIGNA now uses American Specialty Health (ASH) for prior authorization and they do things much differently. They tier providers and the top tier does not have to get prior auth at all.

In 2018, Community Health Options started using Evicore to perform prior authorization. Evicore's business practices were similar to Anthem's current practices – no real use of clinical criteria and pattern of arbitrary approvals and denials. CHO received so many complaints, they stopped using Evicore within 1 year and they do not require prior authorization at all now.

Anthem is a different story. In 2019, Anthem started requiring prior authorization through their subsidiary, AIM (now "Carelton"), for all their insured plans across the country. The requirements are set at the plan level – it is not something providers of any size can negotiate their way out of. Anyone who buys an Anthem fully insured health plan in Maine must get prior authorization for PT and OT services even if you get your services at a hospital-based facility.

Efforts have been made at a national level to address these problems. I have personally served on 2 national task forces on this problem. APTA has tried to work with Anthem since 2019 to address provider complaints but nothing has changed.

Information and Testimony Attached. I have included in your packet an information graphic from APTA that fully describes the problem followed by support letters for LD 1383 from APTA and the Private Practice Section of APTA (“PPS”). I am also delivering written testimony from 10 physical therapy practices and 2 patients who couldn’t be here today. Those letters and the testimony you’ll hear today represent 70+ private practice clinics across the state. The hospitals are affected by this issue too and my understanding is that they support the bill, but I don’t know if they will be testifying.

The patient letters are particularly compelling. One patient was insistent on remaining anonymous because she has required a lot of PT for several medical problems. She is concerned that she might be discriminated against if her health plan finds out who she is. The other patient had her PT benefits arbitrarily cut off after shoulder surgery too early in her post-op protocol. She succeeded in an independent external appeal.

Rationale for LD 1383. The *fundamental* problem is that these utilization management companies are *not* using peer reviewed clinical review criteria. We would like to fix that problem in future legislation. Michigan passed an extensive law in 2022 (that becomes effective in June 2023) requiring carriers to use peer-reviewed clinical criteria and publish their criteria for providers. The utilization review entities we are familiar with do not currently do this and probably are not prepared to do it any time soon, so fixing this fundamental problem is a much heavier lift. Providers and patients can’t wait for these utilization review entities to develop their clinical criteria.

Therefore, we drafted LD 1383 to be a quick fix to the most egregious problem – the unduly burdensome and costly work to get authorizations that are automatically approved and should not require prior approval. It incorporates recommendations for model legislation from the Private Practice Section of APTA.

It is our position that the “over-utilization” the carriers say they are trying to address with all of this unnecessary prior authorization simply doesn’t exist before 12 visits. We don’t think asking to prohibit prior authorization before visit 12 is unreasonable. In fact, Aetna, Martin’s Point and several self-insured health plans set 25 visits as their trigger to review for ongoing medical necessity and require prior authorization. Community Health Options and Harvard Pilgrim have no requirements for prior authorization (per provider reports).

It's worth repeating that LD 1383 does *not* automatically grant all patients any certain number of visits. Visits still have to be medically necessary and carriers can review medical records and deny payment if treatment is not.

We believe there are better ways to deal with the estimated 1% of providers who routinely over-utilize therapy services without putting excessive burdens and costs on 100% of providers. Carriers can always review medical records for medical necessity before or after making payments. They can also kick problem providers out of their networks.

We know many of the carriers will be opposed to this bill - perhaps not because it affects them, but on principle alone – that they should be able to decide when and how to do utilization review and their assumption that all providers will over-utilize services if given the chance.

Where there are valid concerns about the drafting of the language or unintended consequences, we are very willing to work with the carriers to make the bill better as long as it still solves the urgent issues providers and patients are having.

I'm happy to answer any questions you have about any provision in LD 1383 and I will be available at your work session.

Thank you for your consideration of this very important bill.

Gwen Simons, Esq. PT, OCS, FAAOMPT

Gwen Simons, Esq, PT, OCS, FAAOMPT
Lobbyist, Maine Chapter APTA
gwen@simonsassociateslaw.com
207.883.7225

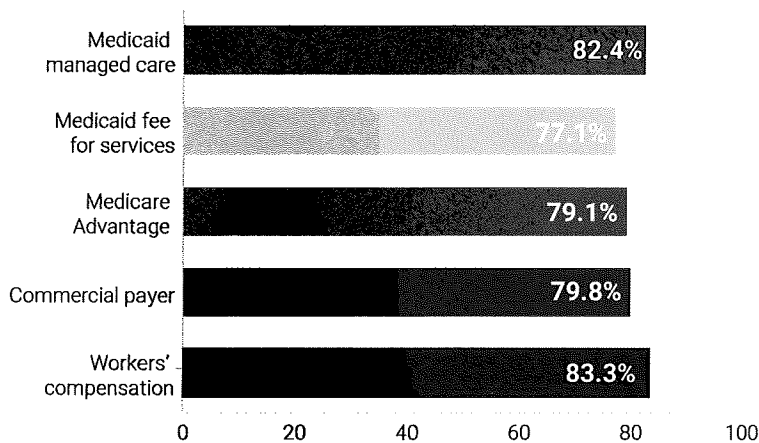
The Impact of Administrative Burden on Physical Therapist Services



APTA members report that medically necessary physical therapist services are delayed – ultimately impacting patients’ clinical outcomes – because of the amount of time and resources they must spend on documentation and administrative tasks. The volume of these tasks also leads to dissatisfaction and burnout. APTA urges policymakers and third-party payers to advance policies that streamline documentation requirements, standardize prior authorization and payer coverage policies, and eliminate unnecessary regulations.

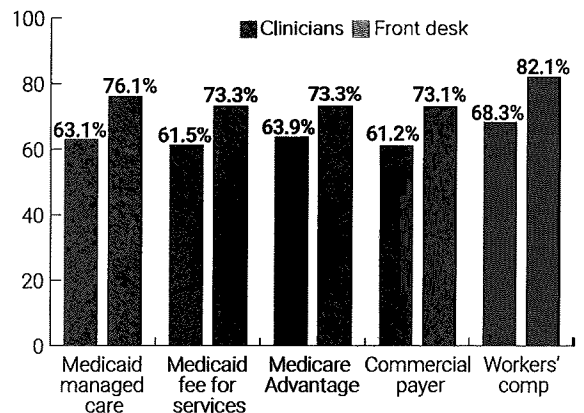
Prior Authorization

Percentage of front desk staff who spend more than 10 minutes to complete a prior authorization for each patient enrolled in these health plans



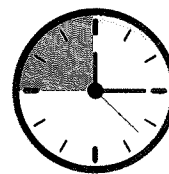
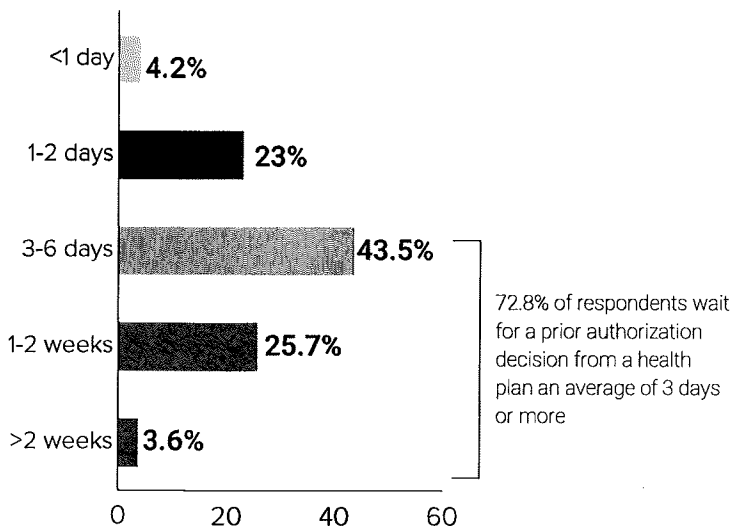
Continued Visits

Percentage of clinicians and front desk staff who spend more than 10 minutes when requesting approval for continued visits for each established patient enrolled in these health plans



Nearly 3/4 of respondents indicated that prior authorization requirements delay access to medically necessary care by more than 25%

Average Wait Time



25% or more

Amount of clinician and staff time most respondents indicated would be saved if Congress constructed legislation that requires standardization of prior authorization forms and processes

80% of Respondents agreed or strongly agreed that prior authorization requirements negatively impact patients' clinical outcomes

More Than 8 out of 10 respondents say administrative burden increases by more than

25%

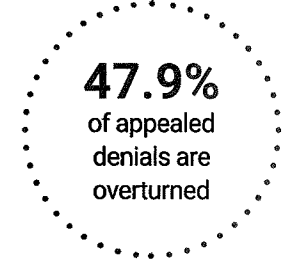
when a third-party administrator is involved



2 in 5 Respondents

say that even after a payer has said prior authorization isn't required, more than 25% of claims are later denied for that reason

Ultimate Outcome of Denied Claims



65%

of respondents say more than 30 minutes of staff time is spent preparing an appeal for one claim

Top 5

items that would reduce administrative burden (numbers represent percentage of respondents)

1 **52%**

Standardization of documentation requirements across all stakeholders

2 **37.4%**

Elimination of requirement for Medicare plan of care signature and recertification

3 **36.8%**

Standardization of coverage policies across payers

4 **34.4%**

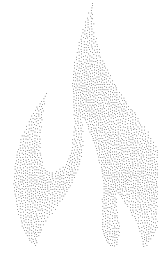
Standardization of prior authorization process

5 **33%**

Unrestricted direct access per payer policies

86.3%

of providers agree or strongly agree that administrative burden contributes to burnout



80.9%

of facilities have added nonclinical staff to accommodate administrative burden

Data is from a web-based survey administered Oct.-Nov. 2022.

Sample size: 15,000 | Respondents: 773

Respondents were screened to ensure that every participant met at least one of these criteria:

- Is an owner/partner of a physical therapy practice.
- Is an administrator/supervisor.
- Provides at least some direct patient care.

Of these:

- 74% practice in outpatient settings.
- 26% are owners/partners of a practice.
- 53% are administrators/supervisors.
- 93% provide at least some direct patient care.



April 12, 2023

Committee on Health Coverage, Insurance, and Financial Services
Maine Legislature
100 State House Station
Augusta, ME 04333

RE: Support for LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Service

Dear Members of the Committee,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association submits the following comments in support of Maine LD 1383, legislation that reduces unnecessary and burdensome prior authorization.

APTA advocates for patient access to medically necessary evidence-based therapy services. APTA members report that prior authorization delays medically necessary physical therapist services — adversely impacting patient clinical outcomes — because of the amount of time and resources they must spend on documentation and administrative tasks. The volume of these tasks also leads to provider burnout and patient dissatisfaction.

Physical therapist services are provided through a plan of care, which is established by the physical therapist's evaluation and outlines the patient's rehabilitation goals. When the plan of care is not fully authorized by an insurance carrier at the outset, the therapist does not know how many visits will ultimately be approved. This can result in delays in care, scheduling challenges, and decreased patient outcomes.

A number of Utilization Review Entities employ arbitrary computerized algorithms to determine how many therapy visits to approve, routinely resulting in failure to authorize appropriate visits. If UREs were to use existing medical evidence, they could approve a reasonable number of visits for an entire episode of care on the first prior authorization request. Instead, providers spend countless hours on paperwork multiple times just to get medically necessary therapy services approved.

APTA works with our state chapters specifically to address problems our members and the patients we serve encounter on administrative burden issues, including prior authorization. APTA and our state chapter also work with commercial payers directly to address these concerns. Most recently these efforts have resulted in changes from Aetna to drop prior authorization in five states. APTA state chapters utilize legislation as a last resort after efforts to work with payers to address such concerns that impact our patients fail to achieve resolution. We believe LD 1383 addresses many of the outstanding prior authorization challenges and will eliminate prior authorizations before any potential for over-utilization exists.

In the best interests of Maine patients and providers, we urge you to vote "Ought to Pass" on LD 1383. If you have any questions or need additional information, please contact Justin Elliott, vice president of government affairs at justinelliott@apta.org or 703-706-3161. Thank you for your consideration.

Sincerely,



A handwritten signature in black ink that reads "Roger Herr". The signature is fluid and cursive, with a long horizontal stroke at the end.

Roger Herr, PT, MPA
President, American Physical Therapy Association



April 11, 2023

Committee on Health Coverage, Insurance and Financial Services
c/o Clerk Edna Cayford
Maine House of Representatives
2 State House Station
Augusta, ME 04333-0002

RE: Please vote “Ought to Pass” on LD 1383

Dear Senator Bailey, Representative Perry and Honorable Members of the Health Coverage, Insurance and Financial Services Committee:

On behalf of the almost 4,000 members of APTA Private Practice, a Section of the 100,000+ member American Physical Therapy Association (APTA), I write to endorse LD 1383 as a model for legislation that will stop the excessive and unnecessary prior authorization requirements that are plaguing private practices across the country and in Maine.

APTA Private Practice is an organization that supports the unique needs of physical therapists who own their own practices. Most of the physical therapists and physical therapist assistants we represent work in Private Practices. Many are small business owners focused on taking care of their local communities. While arbitrary utilization management policies make it difficult for them to sustain their small businesses, the real injustice is that they prevent them from providing the care their neighbors need.

In recent years, our members have become increasingly alarmed about the burdensome prior authorization requirements that many payers are using. As an association, we have assembled task forces to analyze the issues and have found that the algorithms being used to determine whether and how many physical therapy visits are authorized are not based on clinical or scientific evidence. As a result, these platforms cannot determine when care is being over-utilized. They only create additional unnecessary paperwork for the therapist and result in interruptions, delays and denials for patients.

Our Association has tried to work with payers to provide input on changes they should make to their platforms and algorithms so their decisions are evidence-based instead of arbitrary and capricious. We have told the payers that prior authorization should be given for the entire Plan of Care on the first request instead of being given piece-meal with ever-increasing administrative requirements. *Our input has fallen on deaf ears.*

APTA Private Practice
1421 Prince St. Suite 300 • Alexandria, VA 22314 • 800.517.1167

These increasing administrative burdens are putting private practices at financial risk and causing provider burn-out. Several states have resorted to trying to solve this problem with legislation. Our Association has created recommendations for utilization management legislation after analyzing what other states have done and what is needed. LD 1383 incorporates our recommendations by:

- Barring unnecessary prior authorization before the 12th visit
- Requiring a response to a prior authorization request within 24 hours, minimizing the risk of delays in interruptions and care
- Requiring subsequent visits to be approved in 6 visit segments so the patient can receive enough therapy to make progress
- Prohibiting prior authorization for the first 90 days for patients who have a chronic pain diagnosis to increase conservative care and avoid opioids to manage their pain
- Providing a mechanism of retroactive authorization

I urge Maine legislators to rein in the overuse of administratively burdensome prior authorization policies so that patients can access the rehabilitative care they need to avoid pain, improve function, and live better lives, and private practices can remain solvent.

Thank you for your consideration of the views of APTA Private Practice.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Horsfield". The signature is fluid and cursive, with the first name "Mike" and last name "Horsfield" clearly distinguishable.

Mike Horsfield, PT, MBA
President, Private Practice: a Section of the American Physical Therapy Association

April 6, 2023

Dear Senator Bailey, Representative Perry, and Honorable Members of the HCIFS Committee:

I am writing to encourage you to vote *ought to pass* on LD 1383. I am writing this anonymously as I am concerned that Anthem will “blacklist” me or informally discriminate against me in future medical claims if they knew my identity.

I am a patient from Maine that suffers from a poor outcome of a joint surgery. I have a private Anthem insurance plan. My insurance plan requires pre-authorization ridiculously often in order to continue my physical therapy treatment. More than once, this has resulted in delays of approval for future visits which, in turn, interrupts my care. Recently I learned that, due to yet another re-evaluation required by Anthem, I will have to cancel my next appointment as the pre-authorization will not be processed in time. Going through this re-evaluation testing (which is required, on average, every fourth visit) during an appointment takes time away from hands-on therapy and strengthening exercises.

I realize that Anthem’s re-evaluation requirements are intended to prevent overutilization of therapy. I can assure you that this is not the case in my situation. While I am very faithful to work at home with the exercise program outlined by my therapist, this at-home exercise program is not sufficient to match the benefits I receive in my therapy visits.

Having to be re-evaluated every four visits (every other week) has often become emotionally distressing as I have to demonstrate improvement in such a short time period just to be awarded four additional visits. Then I have to repeat the entire procedure again two weeks later.

I began my therapy in late 2022 and, although I have a significantly high deductible to meet in 2023, I chose to continue my therapy. My physical therapist shared with me that, although he understood my financial concerns going into the new year, he wasn’t ready to discharge me by the end of the year based on the work that still needed to be done for the best outcome in my situation. If I don’t continue to work with physical therapy, Anthem will eventually face a much bigger financial hit as I will end up having to have a revision surgery.

Thank you for being willing to hear my concerns. Again, I urge you to vote *ought to pass* on LD 1383.

An Anonymous Patient

Written Testimony in Support of LD 1383

Senator Bailey, Representative Perry and Members of the HCIFS committee:

My name is Marjorie Haney and I live in South Portland. I'm asking you to vote "Ought to Pass" on LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Service.

I am a physical therapist, but I write to you as a patient. I experienced the problems this bill attempts to fix first-hand after I had shoulder surgery on November 24, 2020. My post-op protocol was for 12 weeks of physical therapy. I had to keep my arm in a sling and go to therapy for passive range of motion and joint mobilization for the first 6 weeks before I could start active range of motion. I was not supposed to start strengthening until week 12.

My Anthem health plan was supposed to cover 20 PT visits per year. My PT had to request prior authorization from AIM (Anthem's subsidiary that handles prior authorization) 3 separate times for the first 13 visits I received. After that, Anthem denied all future visits, falsely stating I had not made any progress, but I had. They did not even read my medical records that my PT submitted at their request or they would have known that. More importantly, I was not at the point in my post-op protocol where I was even allowed to start strengthening yet.

My PT immediately asked for an appeal or a peer to peer review with AIM. They said they did not do peer to peer reviews and to call their 800 number to find out how to file an appeal. My PT tried to call that number several days, but it was always busy. It took about a week for me to receive Anthem's denial letter by snail mail, which had the appeal instructions in it.

When I filed the first level of internal appeal with Anthem, they rubber-stamped AIM's denial for the same false reasons - that I had not made progress in PT. I then asked for an independent review through the Bureau of Insurance. That took several days to schedule. But when I had the independent external appeal with a physician who actually read my medical records and understood how many PT visits I was going to need based on the surgery and my post-op protocol, he approved 17 additional visits. Anthem/AIM did not even show up for the appeal to defend why they made false statements that I was not making progress as their excuse to deny the rest of my PT visits.

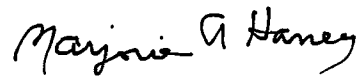
Anthem's/AIM's inappropriate denial of my PT services could have interrupted my care for more than 2 weeks, but my PT continued to see me at risk of my claims being denied. If she had not been willing to do that, I could have ended up with a frozen shoulder. My surgeon was already concerned about that occurring because it is a risk factor after shoulder surgery with inadequate therapy and range of motion.

This experience confirmed to me that the business practices that insurance companies are using to decide whether someone gets to use their covered PT benefits are completely arbitrary. They don't even look at the medical records. They just deny visits to see if they can get away with it.

I'm grateful that now I know how to use the appeals process, but no one should have to go through 2 appeals to get medically necessary visits approved when they have covered benefits available. My employer, who provides my health plan, changed insurers after my bad experience. But other people may not be so lucky. Passing LD 1383 will ensure that people have access to the therapy services their

plan is supposed to cover without the therapist having to jump through so many hoops to get their services approved. And it will help minimize disruptions in therapy when more visits are needed than initially approved. ***Please vote "Ought to Pass" on LD 1383.***

Sincerely,

A handwritten signature in black ink that reads "Marjorie A Haney". The signature is written in a cursive style with a large, stylized 'M' and 'H'.

Marjorie Haney



NEUROMUSCULAR REHABILITATION, PA

Specializing in the treatment of chronic pain
through the use of surface electromyography

RENEE ST. JEAN PT, DPT, CEAS

179 Lisbon St. LL Suite 2 Lewiston, ME 04240 Phone (207) 753-0100 Fax (207) 753-0600

Written Testimony in Support of LD # 1383, AN Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services

Dear HCIFS Committee Members,

My Name is Renee St. Jean, PT, DPT, I am owner of a private physical therapy practice in Lewiston, Maine. I have been in business for the past 23 years and have been a practicing physical therapist for 37 years.

This legislation provides some relief from the overly burdensome and unnecessary prior authorization requirements therapists must utilize on behalf of their patients in order for them to receive normal therapy insurance benefits. In most cases, these online platforms take over 30 minutes to fill out and in reality, the online assessment does not represent the complexities of the actual patient. This is then reflected in the improper number of visits and the improper timeframe allotted to complete these visits, assuming visits were approved.

A common example of improper prior authorization evaluation issues include the ability to only enter ONE diagnosis per patient. Nearly all patients have more than one diagnosis affecting their case complexity and the resulting number of visits needed to treat this patient. Chronic patients having multiple co-morbidities are poorly represented with online prior authorization questionnaires resulting in poorly matched "automated prior authorization" number of visits and timeframes in which to complete these visits. My clinical judgement may find a patient needs one visit every 3 weeks for gradual progression of a home program and I will likely get 4 visits for two weeks. This means that I must REAPPLY for additional visits every single time I see the patient and this situation usually leads to a flagged denial of visits. This means that an arbitrary online algorithm has repeatedly wasted my precious treatment time while denying patients their insurance benefits for proper coverage.

It is appropriate that insurance carriers should AUTOMATICALLY approve a minimum number of visits (10-12 being the norm) and ONLY require prior authorization after this number of visits have been utilized, leaving the medical expert able to determine frequency of visits and time frame of visits without leading to any over utilization of therapy services.

Thank you for your consideration of this most important legislation.

I am available to discuss questions and concerns regarding this proposed legislation at the phone number on my letterhead or by email at reneestjean1@hotmail.com.

Sincerely,

Renee St. Jean, PT, DPT
Owner Neuromuscular Rehabilitation, PA



4/7/2023

Dear Senator Jill Duson and Representative Michael Brennan:

I am a constituent in your district, both as a resident and a business owner. I am a physical therapist and owner of Alliance Physical Therapy in Portland, ME. I'm writing to ask you to support LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services. This bill is scheduled for a public hearing in the HCIFS Committee on April 13. **Please vote "Ought to Pass".**

Over the last few years, the process of pre-authorization for physical therapy has continued to become more burdensome as more commercial insurance companies adopt the process and become more restrictive as they require more unnecessary information and make more denials on visits both in total number and by approving ridiculously low visit numbers at a time. This burden is both in time and energy outside of patient care. It exacts a high cost to the practice through administration expenses as well as further stress on the providers who are already facing a high degree of burnout. It's also costly to the patient by both dominating their time in therapy sessions, as we try to satisfy insurance company requirements, instead of providing appropriate treatment as well as causing interruption of care as the denial and subsequent appeal or peer to peer review process may take 1-2 weeks. Such interruption in care causes delayed and often suboptimal recovery for the patient.

At Alliance Physical Therapy, we service over 1200 patients per year, a vast majority of whom are your constituents. Up to 40% of these patients have insurances that require pre-authorization processes. Each company has a different process, which is its own challenge, but it also results in exorbitant yet avoidable administrative burden. They routinely deny requested visits, even from the initial evaluation and despite demonstrating medical necessity. Another strategy they use is to require such consistent re-authorizations that it becomes impossible to demonstrate progress, a requirement for further visit approval. Each prior authorization takes about 15-30 minutes of administrative workload, and the companies consistently approve less visits than is being requested initially for the full treatment plan. They typically approve 25% of the visits requested initially. With high frequency they will subsequently approve 2-4 visits at a time then dropping to as low as 1-2 visits at a time. It is not unusual for cases that do reach 12 total visits (a typical/average amount for successful completion of care) with at least 3-4 prior authorization requests.

Alliance Physical Therapy, LLC
331 Veranda St, Building 4,
Suite #401, Portland, ME 04103
allianceptme.com

Tel 207 536 0702
Fax 207 536 0784
Email welcome@allianceptme.com



Another huge challenge is typified by Anthem's utilization review entity, AIM (recently renamed "Carelon") which frequently mis-informs our team that prior authorization is either required or not. As you can imagine in instances where it was required but we were told it wasn't, results in lost income for the practice or the full cost being transferred to the patient retrospectively. Conversely, times when they tell us, it is required when it isn't results in even more wasted time, stress and patient angst.

If this bill passes; it will serve to support your constituents who are patients in gaining fair access to physical therapy, it will also support your constituents who are physical therapists and/or practice owners in reducing unnecessary administrative cost, wasted time and guard against unnecessary burnout risk. For both interest groups (patients and therapist) it will support a focus on high quality patient care, access to care and timely and successful rehabilitation/ recovery after injury or surgery which will improve quality of life, contribution to the economy and healthier lifestyles.

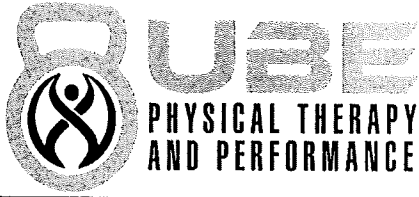
Thank you in advance for your consideration. Please feel free to contact me if you need any further information.

Respectfully,

Philip Chamberlain, PT
Owner and Physical Therapist
Alliance Physical Therapy
Phone: 207 536 0702
Email: phil@allianceptme.com

Alliance Physical Therapy, LLC
331 Veranda St, Building 4,
Suite #401, Portland, ME 04103
allianceptme.com

Tel **207 536 0702**
Fax **207 536 0784**
Email welcome@allianceptme.com



17 Commerce Park
Ellsworth, ME 04605
T: 207-992-4000
F: 207-558-3285
admin@ube-more.com

130 Perry Rd
Bangor, ME 04401
T: 207-992-4000
F: 207-558-3285
admin@ube-more.com

4 Gendron Dr, Unit 5
Lewiston, ME 04240
T: 207-992-4000
F: 207-558-3285
admin@ube-more.com

April 10, 2023

Dear Senator Baily, Representative Perry and Honorable Members of the HCIFS committee:

I am an orthopedic physical therapist that manages three orthopedic and sports physical therapy clinics throughout the state of Maine. I am writing to ask you to **support** LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services.

Our clinicians are very skilled at managing patient care and optimizing outcomes, therefore, we often see cases that have failed physical therapy in the past and their symptoms are chronic in nature, or they arrive with multiple body parts affected. We are asked to obtain prior authorization for many of these cases where the visits allotted do not appear to be based on diagnosis codes, patient complexity or the provider's plan of care and the number of visits dispensed appear arbitrary. This is similar to subsequent authorization requests for continuation of care, in which many of the requests don't require much clinical information, and they approve authorizations with low visit limits. This requires objective clinical changes to be made in a short amount of time and if this change is not deemed sufficient, it is determined that physical therapy is unnecessary. These expectations are unrealistic for patients managing chronic pain or post-operative limitations.

This authorization process places an unnecessary burden on our clinical staff to complete progress reports with increased frequency, as well as the burden on our patients to continually disrupt progress by taking unnecessary time to collect data, and lastly to our front office staff to submit the authorization requests. This potential delay in the patient's progress with frequent progress reports or delays in authorizations only results in setbacks in progress and is cost prohibitive in the long run.

With LD 1383, we would be able to provide care for these patients for 12 visits without disruption of care. This will save time, and healthcare dollars and increase access to care.

In respect of your time, I have limited all aspects in which this authorization process is burdensome and challenging for small private practices. Should you have an interest in other effects of this process I would be happy to discuss them further.

Thank you for your time. If you have any questions, please do not hesitate to contact me.

Cat Kenney, PT, DPT
ckenny@ube-more.com
207-949-0552



Please Vote Ought to Pass On

**LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements
for Physical and Occupational Therapy Services**

Written Testimony from

Village Physical Therapy in Gorham, ME

Senator Bailey, Representative Perry and Honorable Members of the Health Coverage, Insurance and Financial Services Committee:

My name is Debbie Smith and my husband is Mike Smith. He is the physical therapist and owner of Village PT in Gorham and I manage the front office. We urge you to vote Ought to Pass on LD 1383.

Health plans that require prior authorization for PT services are increasingly becoming a problem for our business. Anthem began requiring prior authorization in 2019 when they acquired AIM Specialty Health (now known as *Carelon*), a utilization review entity. It has been a nightmare for our practice and our patients. It has created tremendous administrative burdens and interfered with our patients' access to care.

The AIM platform will not let us request the number of visits we need on the first prior authorization, so we have to get prior authorization 3 times for a standard 8-12 visits in a treatment plan. Their approval algorithm is to approve 4-6 visits on the first request, 2-4 visits on the 2nd request and 1-2 visits for each request thereafter.

These unnecessary prior authorization procedures also increase our costs. We do not get paid for all our time requesting prior authorization, waiting on the phone and filing appeals. We have had to hire staff just to help us manage the authorization process. Each prior authorization takes 20-30 minutes to complete – longer for subsequent authorizations because they often require phone calls (excessively long hold times). Each prior authorization also requires the patient to complete questionnaires and the PT to take (sometimes irrelevant) measurements that are unnecessary just to report required data on the platform. This takes time away from our treatment session. After all this work, AIM routinely auto-approves 8-12 visits.

Village Physical Therapy

381 Main Street, Suite 1 • Gorham, Maine 04038 • (207) 839-9090 • Fax (207) 839-9091

Worse, their algorithm is *not* a medical necessity determination that takes into consideration the patient's diagnosis and co-morbidities. For example, approval of 6 visits for a healthy, fit twenty-year-old whose chief complaint is knee pain, might be appropriate. More visits will be needed for the overweight 75-year-old patient with the same diagnosis who also has diabetes and recently recovered from cancer. This patient's care will likely be interrupted by denials and prior authorization delays because more than the auto-approved visits are needed.

If the patient needs more than 8-12 visits, AIM routinely denies all future visits. We have to put the patient's care on hold while we pursue peer to peer phone calls and file appeals. We are almost always successful when we appeal because we have no problem proving our services are medically necessary, but it is a severe interruption in care and many patients give up while waiting for us to overturn their denials. In a post-op case, delays and early termination of the treatment plan can result in harm to the surgical site. In a total knee replacement patient, it can result in the patient losing range of motion requiring a second manipulation under anesthesia procedure.

We understand the need for insurance carriers to control over-utilization, but increasing the costs for 100% of the network providers just to control the 1% or less of providers who provide unnecessary services is absurd. Insurers should kick providers who over-utilize out of their network and let the rest of us do our jobs.

To be clear, this bill will not result in overutilization. Services still have to be medically necessary to be covered services. We take pride in providing evidence-based care and do not provide treatment that is not medically necessary. Carriers can always review medical records for medical necessity before (and after) paying a claim if they think unnecessary care was provided. We do not need a computerized algorithm to be the judge of what is medically necessary before we even start treatment.

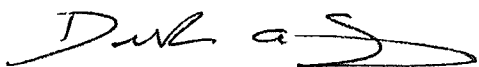
Lastly, we have not had any increases in our reimbursement in, at least, 15 years, so continuing to provide quality care with increasing administrative burdens is unsustainable. If we cannot get relief from these unnecessary prior authorization requirements, we may have to go out of network with some carriers. The prior authorization process should never have a direct effect on patient outcomes, but when the provider and the patient are taken out of the equation, it does.

Thank you for your consideration of this very important bill. If you have any questions, I can be reached at 207-839-9090.

Mike Smith, MSPT



Debbie Smith, Practice Manager





128 Middle St. Farmington, ME 04938
Phone: (207) 778-6469
Fax: (207) 778-3486

April 12, 2023

Dear Members of Health Coverage, Insurance, and Financial Services Committee:

My name is Kathryn Longhurst. I am writing to ask you to support LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services. My husband is a physical therapist, and he has always had a goal of owning his own practice. We were fortunate to be able to purchase a business from his former boss who recently retired and we were able to realize this goal. We have a staff of 10 incredible people and serve the Farmington and Kingfield areas, providing care an area where patients do not have a lot of options for the physical and occupational therapy needs.

One of the most difficult challenges which we did not anticipate was the navigating various insurance companies and their policies. These carriers have requirements which make small business like ours spend a burdensome amount of time verifying their benefits and seek prior-authorization for their care. Our front office staff spends hours each day submitted authorization requests and verifying this information. Additionally, we are often given incorrect information from the carriers. This has been especially difficult recently with Anthem's utilization review entity, AIM/Carelon. At the start of the year, we verify patient's benefits for them so that they do not have an unexpected balance. At that time, AIM informed us that authorization was suddenly required for patients that had never required authorization before. We were later told that they do not need authorization. Recently, we began receiving denials for claims with a letter than these patients do require authorization. I contacted Anthem, and was required to go back and forth a few times between both Anthem and AIM, resulting in hours on the phone. Additionally, we have patients whose plan of care is interrupted or goals are limited by the number of visits approved by their insurance or utilization review entity. Oftentimes, we do receive authorization but it is only for 2 or 3 visits, and our front office and therapy staff are repeating the lengthy process every week to obtain authorization for these patients.

Thank you very much for your time and attention in this matter. I sincerely hope that you will consider supporting LD 1383 to give power back to small businesses like ours and help us focus on caring for our patients.

Sincerely,

A handwritten signature in black ink that reads "Kathryn Longhurst". The signature is fluid and cursive, written over a white background.

Kathryn Longhurst
Vice President
Allied Physical Therapy



Southern Maine Physical Therapy, P.A.

449 Cottage Road, South Portland, ME 04106

Phone: (207) 799-9700

Fax: (207) 799-9706

www.smpt.biz

HCIFS Committee
c/o Legislative Information Office
100 State House Station
Augusta, ME 04333

April 11, 2023

Dear Senator Bailey, Representative Perry, and Honorable Members of the HCIFS Committee:

Southern Maine Physical Therapy is a small, privately owned physical therapy practice in South Portland. We are writing to ask you to support LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services.

The amount of time we spend requesting prior authorizations for patients is staggering. We first need to verify if the patient's insurance plan requires prior authorization and are often given false information from this very first step. There have been many cases in which our admin team was told prior authorization was not required, but claims were then denied for lack of authorization. We have also had carriers inform us prior authorization is required when it is not. Both instances take unnecessary time away from patients. LD 1383 proposes that carriers would not require an authorization for 12 visits per new episode of care. Not only would this allow us time to treat the patient as medically necessary, but we would also learn about the patient's situation and obstacles. Currently we only have information from an initial evaluation – one interaction – when applying for authorizations. If we were allowed to see a patient for 12 visits before needing to apply for authorization, our administrative team would also have the time to work out any misinformation from the carrier before it interferes with the patient's care. We estimate that it takes an average of one hour per authorization request; many cases require us to place up to three requests per plan of care – that's three hours per patient, per episode of care, and that does not include the additional time required if extra documentation is requested by the carrier, or if authorization is denied and our therapists need to complete a peer-to-peer review.

Now that physical therapists have Doctorate degrees, their salaries have appropriately increased. Small businesses have had to absorb that extra payroll cost because they've received only a very small, if any, increase in insurance reimbursement in years. Because of the increase in payroll and loss of patient visits due to lack of authorizations, it is becoming more difficult for private practices to stay afloat. In fact, we are analyzing data to determine if we should

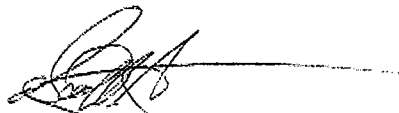
terminate our contract with certain carriers due to the time and cost of doing business with them.

LD 1383 has the potential to improve patient care and outcomes as the current system allows for insurance carriers to, what is seems like, arbitrarily limit the number of visits allowed for a patient based on surface level information provided by generic questionnaires. As experienced professionals, physical therapists write a detailed plan of care after the initial evaluation that clearly states how many visits are needed to meet their goals and the patient's goals. If a patient progresses faster than expected, or is having more difficulty than expected, the plan of care is adjusted throughout the entire episode of care by the educated professional. The algorithms used by third party utilization management companies seem to have a distorted view of how quickly patients can make progress. Therapists can't hurry up the physiology of the body. Over the years, insurance has forced therapists to focus on function only. However, to improve function to a safe level and prevent further injury, there must be improvement in strength, flexibility, soft tissue integrity, range of motion, balance, coordination, and endurance. Therapists use functional therapeutic activities to improve the physiological areas, but it takes time for it all to come together. When we are granted only two to six visits per request because the reviewers don't see progress, it is unfair to the patient, and causes providers and patients to be caught in a cycle of confusion and frustration over what it will take for these companies to allow the patients, who pay for their coverage, the rights of using the visits that they are paying for in their selected plans.

The entire staff at Southern Maine Physical Therapy is strongly in favor of LD 1383, as we see its potential to improve patient care and lessen the administrative workload for our staff and the staff of carriers and utilization management companies. We want to stress that in no way do we expect any change to medical necessity guidelines and will not treat patients if we do not believe what we offer is medically necessary for their recovery.

Thank you in advance for your consideration. Please feel free to contact us if you need any further information.

Respectfully,
Southern Maine Physical Therapy

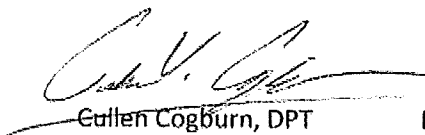


Scott Ayre, OCS, DPT
Owner, Therapist

Brenda Ayre, PT
Owner, Therapist



Sarah Williams
Office/Billing Manager



Cullen Cogburn, DPT
Therapist

Russell Curl, DPT
Therapist



Gail Robertshaw
Office Assistant

Brianna Wallin
Office Assistant



Foothills Physical Therapy, P.A.

*Orthopedic Manual Physical Therapy
Sports & Work Injury*

16 Old Pike Rd., P.O. Box 48
Cornish ME, 04020
Tel: (207) 625-4300
Fax: (207) 625-7300

*Tom J. Thoman, PT, DPT, OCS
Jim G. Stevenson, PT, FAAOMPT
Hayes A. Sweeney, PT, MPT
Kristen L. Pease PT, DPT
Jacklyn L. Locke, OTR/L*

I am a physical therapist and owner of Foothills Physical Therapy in Cornish, Maine. We have been in business for 15 years. I'm writing to ask you to support LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services. This bill is scheduled for a public hearing in the HCIFS Committee on April 13.

Our physical therapy clinic serves a wide area of surrounding communities. Our patients depend on us for their rehabilitation needs and our rural location allows them to stay local and avoid a long drive to urban locations. Over the years insurance carriers have implemented burdensome, costly and unnecessary prior authorization requirements that interfere with our ability to provide cost-effective physical therapy treatment. Carriers will not approve the full number of visits we need in our physical therapy plans of care. They routinely only approve 4-5 visits on the first request and then require additional prior authorization for every 1- 2 visits after that. Not only does this disrupt patient care but it also adds a heavy administrative burden and cost. This legislation, if enacted, will enable us to apply a more seamless plan of care for our patients and will improve the overall efficiency of our clinic.

Thank you in advance for your consideration. Please feel free to contact me if you need any further information.

Respectfully,

Tom Thoman, Doctor of Physical Therapy, Orthopedic Certified Specialist
16 Old Pike Rd
PO Box 48
Cornish, ME 04020
207-625-4300
foothillspt@foothillsptmaine.com

Resilience Maine

REFRAMING AGING WITH PHYSICAL THERAPY

April, 6, 2023

Dear HCIFS committee members. My name is Bill Anderson and I am a physical therapist with over twenty years of experience and with a private practice in Scarborough, Maine. I am urging you to support LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services.

When a patient has an urgent need for physical or occupational therapy, pre-authorization requirements do nothing but limit access to care in a timely manner. They also can create gaps in care with approval delays, having to navigate antiquated online portals, and non-reimbursable time spent having to call to speak with a peer reviewer when we are denied further visits. In addition, we are usually speaking with a peer with limited information with current clinical best practices. Of great concern are insurance companies using AI and algorithms to predetermine approval for care in ways that are not transparent.

There are many physical therapists who are now transitioning to cash-pay practices and no longer accept insurance because of these issues. This is creating a two-tiered health system where if you have resources, you can access physical therapy when it is required, but if you need to use your health insurance, you will have to experience a limitation in provider choice in addition to the aforementioned issues. If this trend continues, limitations in access to physical therapy care will continue to grow.

Supporting LD 1383 will allow patients to receive equal access to care and help to reduce healthcare disparities by allowing 12 visits prior to the need to go through preauthorization.

Thank you for your time considering this important matter. Please feel free to contact me if more information is required.

Sincerely,



Bill Anderson, PT, DPT, GCS

110 Marginal Way #964 Portland, ME 04101-2442
Phone: 207-707-5300 Fax: 207-208-8775 email: info@resiliencemaine.com

www.resiliencemaine.com



DRAGONFLY

PHYSICAL THERAPY

4/6/2022

To Whom it May Concern,

My name is Kristi Smith. I am the office lead at Dragonfly Therapy and have worked at Dragonfly Therapy for five years. My position requires me to be heavily involved in our billing and insurance issues. I am writing in support of LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services.

Requesting prior authorization from insurances has become a huge administrative burden on our office. Each prior authorization takes us anywhere from 15-30 minutes for initial requests. Subsequent requests often take longer as we are required to not only enter additional information but are required to enter information already submitted with any previous requests. This takes administrative employees away from other important tasks we need to do, such as caring for our patients. Frequently, authorizations approved after the initial request are only for two-four visits, resulting in an increase in our workload as we must submit authorizations more frequently.

Some insurance companies make authorization submissions much more difficult than others. One company in particular, will not allow us to request any changes to an already approved authorization, such as a date change if we make an input error or if the patient has not used up approved visits before the allotted timeframe, they require we enter a whole new request. This is extremely inefficient for us and for the insurance company.

Increasing our administrative burden and pulling our therapists away from patients to do a peer-to-peer reviews, is creating a financial hardship as the insurance reimbursements are not increasing with the wages we are needing to pay our employees to provide excellent patient care and to keep our office running effectively and efficiently.

Thank you for your consideration.

Sincerely,

Kristi Smith
Office Lead

March 31, 2023

Dear HCIFS committee members

I am a pediatric physical therapist that oversees 4 pediatric clinics in Maine as well as the Chair for the payment and policy committee for the Maine Physical Therapy Chapter.

I am writing to ask you to support LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services.

Working with children with special needs, we are asked to obtain prior authorization from many insurance companies in order to provide treatment. When we do this for the first time, we are often allotted 6 visits, after 6 visits, we then have to request another authorization and are typically provided with 3-5 visits, the third time we are authorized 1-3 visits. This is a typical pattern with many of the insurance companies regardless of the age of the patient. When working with children with special needs, such as cerebral palsy, down syndrome, attention deficit disorder, and or autism, it takes many visits in order for us to see improvements and progress with their therapy.

This unnecessary burden that is required in order to provide care can be a barrier to access to therapy. Often, we have to cancel a visit while waiting for this process, delaying even more the care for a child.

With LD 1383, we would be able to provide care for these children for 12 visits without disruption of care. This will save time, healthcare dollars and increase access to care.

I urge you to support LD 1383 so that our patients in the State of Maine can access care without unnecessary administrative burden and wait times.

Thank you for your time.

If you have any questions, please do not hesitate to contact me.

A handwritten signature in cursive script that reads "Jen Corbeil".

Jen Corbeil, PT
Physical Therapist



91 Camden Street, Suite 401
Rockland, ME 04841
Phone 207-330-0298
Fax 207-353-0629

November 2nd, 2022

Dear Honorable Members of the HCIFS Committee:

I am a physical therapist and owner of Continuum Physical Therapy in Rockland, Maine. I'm writing to ask you to support LD 1383.

I'm sorry I am unable to be there, but I have a full caseload today. I wanted to share with you three cases that have all gone to the external appeal process when people were denied care here at our clinic. None of the cases have been resolved despite hours of time spent by the patients, myself and our office manager trying to navigate the appeals process. All three cases we have sent to external review were denied further care on the basis that the care was not medically necessary.

The first case was denied late in 2022 after 4 visits. He had almost a year of low back pain that had begun to radiate down his leg. He had intermittent pain at that point and we had begun to make some progress on severity and frequency of pain. He did a couple more visits paying out of pocket, but eventually decided to get further imaging, which I believe he had to pay for himself, and served only to confirm our provisional diagnosis. I am unsure if his issue is resolved now, but I believe that I could have helped him if his care had not been prematurely ended.

The second was denied after 8 visits. This patient had almost 2 years of headaches, neck pain, jaw pain, and ear pain that can significantly limit her ability to perform her work as the owner and manager of a local marine mechanics shop. She has continued to come to therapy after her denial, and pay out of pocket. She has continued to make slow but significant gains in pain levels and function since her denial, but has been unable to use her insurance. This case is the only case that the external review has even been scheduled. The meeting is tomorrow despite filing for the appeal more than 2 months ago.

The third case is a post op total shoulder replacement of a local parole officer. Her therapy was prematurely ended at 12 visits prior to her even entering the strengthening phase of her protocol. She has also continued therapy as her job description requires her to be able to be able to "control a client" if necessary. She had not even been allowed to start lifting weights or using resistance bands when it was deemed that she no longer needed therapy.

I believe that in each of these cases that patient care was interrupted or completely stopped without reason or justification. I have had no issues with other insurance companies questioning

medical necessity. I feel that Anthem patients are being underserved by their insurance company and the authorization process that serves only to cause headaches for providers and the insured. I sincerely hope that this can be resolved.

Respectfully,

Sam Powell, DPT
spowell@UNE.edu
207-593-6682