APTA Maine
A Chapter of the American Physical Therapy Association

Testimony in Support of LD 796, An Act Concerning Prior Authorizations for Health Care Provider Services

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

My name is Gwen Simons. I am the lobbyist for the Maine Chapter of the American Physical Therapy Association (MEAPTA). I am a physical therapist myself and a healthcare lawyer in Scarborough. The Maine APTA represents over 2500 physical therapists (PTs) and physical therapist assistants (PTAs) in Maine.

We are in support of LD 796, *An Act Concerning Prior Authorizations for Health Care Provider Services.* LD 796 is largely codifying into statute what is already in Bureau of Insurance Rule 850 and already required under the Affordable Care Act - with a few additions that we support. We also note that it is consistent with what we proposed in LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services.

We especially like the requirement to exempt healthcare providers from utilization review if the insurer has issued certifications for 80% or more of that provider's request in the last year. When we introduced LD 1383, An Act to Regulate Insurance Carrier Prior Authorization Requirements for Physical and Occupational Therapy Services, we told you that utilization review entities for therapy services routinely approve the first 3 requests for therapy visits. Anthem's own testimony stated that 89% of PT and OT patients do not request additional visits more than twice. Our calculations of those statistics indicate that most, if not all, therapists in Maine will surpass this 80% threshold and be exempt from having to obtain prior authorization. However, the devil is in the details on how this 80% threshold will be calculated and how the Bureau will enforce this provision. Therefore, we believe passing Representative Perry's bill, LD 1498, *An Act to Create an Advocacy and Complaint Process for Health Care Providers Within the Bureau of Insurance* will be essential to ensure compliance with any provisions that apply to providers.

We would like to make a few suggestions for friendly amendments to improve this bill even further.

1. Section 4304(1)(C) talks about the standards for utilization review and (10) requires disclosure of the UR *procedures,* **but neither of these sections clearly require the insurer to disclose the *clinical review criteria* to providers and patients.** We have not been able to get the "clinical review criteria" incorporated into computer generated algorithms because the UREs claim they are "proprietary." If the URE refuses to disclose the criteria, how do we know it is based on medical evidence at all?

   We are also seeing UREs create "clinical criteria" that is not related to medical necessity at all, but instead is based on nitpicky documentation requirements that the URE establishes so it will

have an excuse to deny visits.

The solution is to add a clear requirement to make clinical review criteria readily accessible and conspicuously posted on its website to insureds and healthcare providers as required in Michigan's new law governing UR.

2. We also recommend adding a requirement for the insurer or its designated URE to obtain input from actively practicing Maine healthcare providers whose services will be reviewed by the criteria the URE is using.

3. We agree with the requirement for reviewers to have to be licensed in Maine, but we prefer Maine's existing requirement for the reviewer to be a "clinical peer" versus having to be a medical doctor. For ancillary services, such as physical therapy, a licensed physical therapist is qualified to be a reviewer in addition to a medical doctor who practices medicine in the area of the service being reviewed.

4. In section 4301-A (21), Line 3, we recommend changing "medical doctor" to "healthcare provider" so that it reads,

   "Urgent healthcare service" means a healthcare service with respect to which the application of time periods for making a non-expedited utilization review which, in the opinion of a ~~medical doctor~~ healthcare provider with knowledge of the person's medical condition could either (i) seriously jeopardize the life or health of the covered person or the ability of the cover person to regain maximum function or (ii) subject to covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review. The term urgent healthcare service shall include mental and behavioral healthcare services.

   This change is necessary for non-physician health care providers' opinions to be given deference by insurers when we are asking for concurrent care or urgent care appeals to be expedited. Without this change, insurers can refuse to apply the appropriate time frames to prior authorization denials of ancillary healthcare providers.

In summary, we are interested in working with the proponents of LD 796 to see if it eliminates the need for some of the provisions in our prior authorization bill, LD 1383.

Thank you for your thoughtful consideration of these utilization review issues.

I can be reached at gwen@simonsassociateslaw.com or 207.205.2045 if you need any additional information.

Respectfully,

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