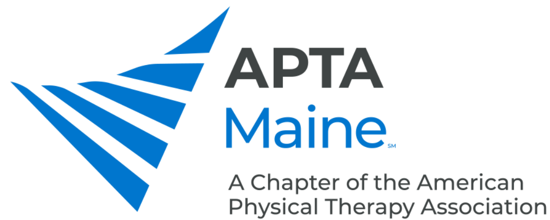


Testimony in Support of LD 1317, An Act To Regulate Insurance Carrier Concurrent, Prepayment and Postpayment Review

Public Hearing, Health Coverage, Insurance and Financial Services Committee
April 14, 2021

Senator Sanborn, Representative Tepler and Members of the HCIFS Committee:

I'm Gwen Simons, lobbyist for the Maine Chapter of the American Physical Therapy Association (MEAPTA), which represents all the licensed physical therapists and physical therapist assistants in Maine.

MEAPTA brought this bill forward after three physical therapists in private practice were recently put on prepayment review ("PPR") by Anthem and had such extraordinary problems getting paid that it threatened the viability of their practices. You will hear from the owners of those practices today.

Our national association, APTA, has been concerned about the growing problems audits, recoupments and prepayment review processes are causing PTs across the country. I have included a support letter from APTA for LD 1317 in my support documents. Carrier documentation requirements are becoming unnecessarily excessive and inconsistent with professional standards. Documentation audits are being done by unqualified people who don't always understand what they are reading in the medical records. Access to and quality of care are impacted when providers can't get paid for services health plans claim to cover. More and more providers are going out of network across the country because of these excessive administrative burdens that carriers place on providers.

This bill is long, so I have submitted a document that provides for each provision the rationale, an analysis of other similar Maine and federal laws that already exist and regulate what this bill seeks to regulate, and a statement of what the bill does ***not*** do in an effort to clarify the bills' intent.

In summary, LD 1317:

- Puts requirements in place for carrier prepayment review procedures to ensure providers' (patients') claims are fairly adjudicated, promptly paid, and patients are not denied appeals that they would otherwise have.
- Establishes limits on the documentation standards carriers can require so carriers cannot require extraordinary, unnecessary documentation merely as a pretext to deny claims.
- By establishing rules that require carriers to adjudicate and pay claims subject to PPR more promptly, it allows providers to timely bill their patients. More patients will be able to use their Health Reimbursement and Flexible Spending Accounts as a result.

- Requires carriers to provide an appeal right to providers who dispute the audit findings that resulted in them being put on prepayment review.
- Prohibits carriers from using prepayment review as retribution for the provider raising contract disputes.

The intent of the bill is *not* to:

- Expand any appeal rights that patients don't already have (therefore this bill should *not* require a fiscal note).
- Require the Bureau to get involved in provider appeals except where the provider has been appointed as the patient's authorize rep, which is already required by Maine and federal law.
- Require the Bureau to get in the middle of provider-carrier disputes.

We have already made amendments that we believe address all the Bureau's concerns and are open to further discussions of any unresolved issues. Those amendments will be provided before the work session.

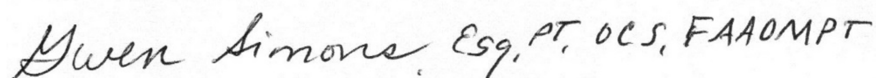
We will also be making an amendment to Section D to replace "Medicare" standards with "professional standards" established by the professional association of the provider being reviewed. We are also willing to work with the carriers on any concerns they have.

To be clear, this bill *is* intended to establish laws that regulate the provider-carrier contract. That does *not* mean the Bureau has to regulate that relationship. The provisions that apply to the provider-carrier relationship merely give the provider a cause of action in a legal dispute should the carrier violate this new law. The method of resolving such disputes will still be in accordance with the dispute resolution clause of the provider agreement if the provider is in-network. If the provider is out of network, the bill will give consumers a cause of action against their health plan if the consumer's claims are wrongfully denied in non-compliance of this bill.

There are numerous already existing Maine laws that regulate the provider-carrier agreement – including but not limited to laws requiring prompt payment, regulating termination of providers from carrier networks, requiring notice for contract amendments, requiring carriers to timely credential new providers and pay providers whose credentialing application was pending when services were provided.

This legislature has also recently passed laws that regulate for pharmacy providers many of the *exact same issues* we are asking the legislature to pass in LD 1317, including the regulation of pharmacy provider audits. (see 24-A MRSA §4317). Therefore, providers are *not* asking for anything unreasonable in this bill.

Thank you in advance for your careful consideration of this bill. I am available anytime to answer questions and will be available for your work session.



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Detailed Discussion of LD 1317:

Rationale, Analysis of Similar Existing Laws and Discussion of what the bill does *not* do

Provided by the Maine Chapter, APTA
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Provision in LD 1317	Rationale	Similar existing law	What the provision does NOT do
Section B – Requirement to allow providers documentation and claims to be submitted electronically when provider is under prepayment review.	-Carriers already have the capacity to accept electronic documentation, so there is no good reason to require it to be submitted on paper by snail mail. Requiring paper submission by mail only serves to give carrier excuses to deny receipt of claims/documentation. -Requiring submission of paper records dramatically increases the cost and administrative burden on a practice unnecessarily. -Requiring submission of paper records and claims makes it impossible for the provider to prove timely filing and receipt. -Requiring paper records increases the likelihood of carrier error because they have to scan in all the documents. Providers should not be punished for carrier error.		This provision should not burden carriers at all. Requiring this in law does not interfere with the provider-carrier contract any more than existing law requiring providers to submit claims electronically does.
Section C – Requires audit/review to be done by clinical peer. Same clinical peer should review all records of individual enrollee. Same clinical peer who reviewed the claims must be available	-The purpose of the carrier wanting to review the provider's documentation before paying the claim is to ensure the services are medically necessary covered benefits and properly coded. This is, by definition, utilization review. As such, it should be	24-A MRSA §4301-A defines clinical peer. 24-A MRSA § 4304 (7) requires a carrier to use a clinical peer when conducting an appeal of an	Carriers already claim they use qualified health care providers to review prepayment claims (though they won't disclose who the reviewers are or their qualifications). If that is true, this section does not put any additional burdens on the carrier.

to provider to answer questions when claims are denied.	subject to existing Maine law (24-A MRSA §4304(7) that requires use of a clinical peer. -When reviewing medical records for whether the care/claims are medically necessary and covered benefits, the same reviewer should review the entire episode of care in order to see the progression of the patient. It is not always possible to make reasonable judgments about whether individual treatment sessions are medically necessary when viewing records of individual visits in a vacuum. -Providers should be able to contact the person who actually reviewed the records if there are questions about the reviewer's decision/denial. The provider should have the opportunity to rebut the reviewer's decision or point the reviewer to the content in the record that supports their claim and/or medical necessity. -If the purpose of the prepayment review is to educate the provider on what documentation is necessary to support the claim, the carrier should be more than happy to allow the reviewer to talk to the provider – otherwise the provider has no feedback on how to correct future claims and continues to be stuck in prepayment review.	adverse health care treatment decision. 24-A MRSA §4317 requires carriers to give pharmacy providers a notice that specifies" all defects or improprieties in the claim and list all additional information or documents necessary for the proper processing and payment of the claim." That is essentially what we are asking for in this provision – that the person who actually did the review be available to the provider to inform the provider about the perceived documentation insufficiencies. See also 29 CFR § 2560.503-1 for Claims procedure rules for patients under ERISA law. See 45 CFR § 147.136 for Internal claims and appeals and external review processes for patients who have individual health plans.	Allowing the provider to talk to the actual reviewer will promote earlier, more efficient resolution of disputes and reduce costs for both the provider and the carrier. This section does not require the Bureau of Insurance to interfere in the provider-carrier contract. It merely gives the provider a cause of action in a contract dispute if the carrier violates this provision when denying patient claims that are under prepayment review.
Section D – We will be proposing an amendment to this provision that deletes the reference to Medicare documentation standards and replaces it with a reference to	-MEAPTA is seeing increasingly burdensome and unnecessary documentation requirements being implemented by carriers that go far beyond professional standards and expectations. We believe this is merely a	There are no state or federal laws that we know of that address this problem, primarily because it is a new and growing problem. That does not mean Maine should not regulate this issue. ***When carriers***	This provision does *not* require a carrier to use any particular standards to review documentation, it just prohibits them from using standards that *exceed* all professional expectations.

the standards set by the professional association of the provider whose documentation is being reviewed.	pretext for denying claims and should be unlawful. **-Example of Problem:** APTA recently reported that Optum Health (United HealthCare URE/PPO) was requiring PTs to document exactly how much time (in seconds and minutes) each individual exercise took within each 15-minute therapeutic exercise intervention. This is absurd and would require the PT to be watching a stop-watch and doing unnecessary documentation instead of watching and giving feedback to the patient during the exercise intervention. AMA coding standards, physical therapy professional standards and even Medicare rules do not require this level of documentation to support a claim. The provider should merely have to describe all the exercises done during the intervention and the total time the intervention took. **-Example of Problem:** Anthem has denied PT claims because the PT did not state that she/he "monitored" the treatment intervention even though the documentation described exactly what the therapist did to monitor it. The PT should not have to use the exact word "monitored" in order to get paid when their documentation clearly indicates monitoring was done.	***set unreasonable documentation standards as a condition of payment, it is a constructive exclusion of the benefit that is supposed to be covered.*** This harms the patient!	This section does not require the Bureau of Insurance to interfere in the provider-carrier contract. It merely gives the provider (and the patient) an argument for an appeal and a cause of action in a contract dispute if the carrier violates this provision when denying patient claims that are under prepayment review.
Section E – Prohibits carrier from denying claims solely on basis of minor documentation errors or omissions that have nothing to do with whether the service was medically	This provision is intended to prohibit a carrier from denying claims based on minor errors or omissions in the documentation and requires carriers to allow providers to correct such minor errors (or accept documentation that has already been corrected).	24-A MRSA §4317 (2)(E) – Pharmacy provider statute for prompt payment of claims explicitly allows pharmacy providers to resubmit corrected claims after the carrier informs the provider about what	This section does not require the Bureau of Insurance to interfere in the provider-carrier contract. It merely gives the provider (and the patient) an argument for an appeal and a cause of action in a contract dispute if the carrier violates this provision when

necessary or a covered benefit.	**Examples of such harmless errors are:** -An EMR program does not capitalize the first word in a list of symptoms -An incorrect pronoun for the patient was used in one sentence in the record but not in the bulk of the record. -The year on the date of the service was incorrectly entered on one progress note right after the new year (easily correctable and obvious data entry error). -Data entry error in *one* place in the record states "right" instead of "left" (correctable error) where describing what extremity was being treated but the rest of the record was correct, making it obvious that there was a harmless clerical error that could be corrected.	documentation deficiencies mad the claim not "clean". This should be allowed for all providers. Professional licensing standards *expect* providers to correct *all* errors in an amendment to the medical record. This provision is merely requiring the carrier to *accept* a corrected record and not deny payment just because a minor clerical error was made. It would be unlikely for a patient's health plan to make coverage on a benefit be contingent on the provider's records not containing any correctable and minor errors or omissions.	denying patient claims that are under prepayment review.
Section F – Requires claims on prepayment review to be paid within 30 days like all other clean claims.	*But for* the carrier putting the provider on prepayment review, the provider's claims would be a "clean claim" and subject to the requirement to pay (or adjudicate) the claim within 30 days. *The carrier should not be able to circumvent this law merely by putting the provider on PPR* – especially when the provider disputes the reasons the carrier has for putting the provider on PPR. If the carrier thinks the provider's claims legitimately require PPR, they should have the capacity to review the documentation and process the claim within 30 days. Providers on PPR are reporting it is taking Anthem an average of 4-5 months to process the initial claim and 9 months to more than 2	24-A MRSA §4317 (2)(D) sets similar requirements for carriers paying pharmacy providers. It states, "A claim is considered to be a clean claim if the carrier involved does not provide notice to the pharmacy provider of any deficiency in the claim within 10 days after the date on which an electronically submitted claim is received or within 15 days after the date on which a claim submitted otherwise is received." (E) further states, "If a carrier determines that a submitted claim is not a clean claim, the carrier	This does not put any unreasonable burdens on the carrier to review the claim in 30 days. The carrier is the one demanding the prepayment review, so the carrier should bear the burden of getting it done in a timely manner.

	years when claims are appealed. **This interferes with the provider's ability to timely bill the patient for the part of the claim that is the patient's responsibility, which in turn, can result in the patient not being able to use funds otherwise available to them in a Health Reimbursement or Flexible Spending Account.**	shall immediately notify the pharmacy provider of the determination. The notice must specify all defects or improprieties in the claim and list all additional information or documents necessary for the proper processing and payment of the claim. If a pharmacy provider receives notice from a carrier that a claim has been determined to not be a clean claim, the pharmacy provider shall take steps to correct that claim and then resubmit the claim to the carrier for payment." (F) further states, "A claim resubmitted to a carrier with additional information pursuant to paragraph E is considered to be a clean claim if the carrier does not provide notice to the pharmacy provider of any defect or impropriety in the claim within 10 days of the date on which additional information is received if the claim is resubmitted electronically or within 15 days of the date on which additional information is received if the claim is resubmitted otherwise." ***This is exactly what we are asking for in this Section F and H below.***	
Section G – An amendment to this section will simply make it clear that the patient has the	This makes it clear that it is the underlying reason for the denial that creates an appeal right for the patient and that right does not	24-A, Chapter 56-A, Maine Bureau of Insurance Rule 850 and	This provision does *not* give the patient any greater appeal rights than they already have.

same appeal rights that the patient would have for the underlying reason for a denial.	change merely because the denial came through a prepayment review process. This addresses the situation where the carrier tries to characterize a prepayment denial is a “customer service issue” or a “provider contract issue” that is not entitled to an appeal when the real reason for the denial is that the carrier does not believe medical necessity has been proven by the documentation. All medical necessity determinations are entitled to an appeal under existing Maine and federal laws.	Federal law clearly defines what carrier denials entitle the patient to an appeal. The carrier cannot circumvent these consumer protections by claiming a denial is merely a provider-carrier contract dispute or a customer service issue. Maine and federal law also allow the patient to appoint a provider as his/her authorized representative to pursue appeals. Authorized Representatives get to step into the shoes of the patient to appeal denied claims. See 29 CFR § 2560.503-1 for Claims procedure rules for patients under ERISA law. See 45 CFR § 147.136 for Internal claims and appeals and external review processes for patients who have individual health plans.	It does <u>*not*</u> give the provider any appeal rights that the provider can’t obtain by getting the patient to appoint them as the Authorized Rep. This provision does not require the Bureau of Insurance to do anything it doesn’t already have to do for patient appeals. It will not result in any *more* appeals because it doesn’t expand the patient’s appeal rights.
Section H – Requires carrier to inform provider of what additional information is needed to adjudicate a claim when the carrier states it does not have enough information.	Providers under PPR are reporting that denial reasons on EOBs make blanket statements that “claim lacks information” or “attachment is needed” without stating what information they are looking for. The provider believes all information necessary to process the claim has been submitted. Carriers should be required to tell the provider what information they think is missing so the provider can point the reviewer to the information if it is in the records submitted or provide the information if it is readily available or can be obtained.	As stated above for Section F – there are Maine laws [24-A MRSA §4317 (2)(E)] already in existence that require this for pharmacy claims. Why wouldn’t Maine require this for all provider claims? When carriers deny or fail to approve covered services for a patient because they need additional information to determine whether the service is	This *does not* place an additional burden on the carrier – they already have to inform patients of what information is needed to perfect their claim under existing laws. This section just requires the carrier to also provide that information to the provider. This provision <u>*does not*</u> give the patient any rights the patient does not already have.

		medically necessary or a covered benefit, the carrier is *required* to inform the patient about what specific information is needed for the patient to "perfect" their claim. Why should this be any different for providers? After all, it is the same patient claim. Providers should be informed of what information is needed by the carrier for the carrier to adjudicate the claim and then the provider be allowed to provide such information. See 29 CFR § 2560.503-1 for Claims procedure rules for patients under ERISA law. See 45 CFR § 147.136 for Internal claims and appeals and external review processes for patients who have individual health plans.	This provision does not require the Bureau of Insurance to do anything.
Section I – Requires carrier to consider the requested additional information provided by provider as being timely filed if the original claim was timely filed.	Provider on PPR are reporting that when additional information is provided to Anthem (at their request) or when documentation is sent for the 2nd, 3rd or 4th time because Anthem claims not to have received it, Anthem is denying the claims because the timely filing deadline has run out. BUT FOR Anthem making errors in scanning in the records that were mailed, the records would have been timely received. When the carrier claims not to have received documentation that the provider sent or the carrier chooses to require additional information, the claim should not be considered untimely filed if the		This section does not require the Bureau of Insurance to interfere in the provider-carrier contract. It merely gives the provider (and the patient) an argument for an appeal and a cause of action in a contract dispute if the carrier denies a claim for untimely filing when the original claim was timely filed *but for* the carrier losing the documentation or requesting additional documentation.

	original claim was timely. Section B and H go hand in hand with this provision.		
Section J – Requires carrier to give accurate information on how the provider can appeal a denial. An amendment to the bill will strike the last sentence in Section J so as not to create new appeal rights under Rule 850 for providers.	This is not an uncommon problem across many carriers. They denial letter that the provider gets has an incorrect fax number or incorrect P.O. Box listed as where to send appeal requests. In a recent case that went to an Independent External Review (that the patient won), the utilization review entity for Anthem told the provider to just keep calling them back on their 800 number when the provider inquired about how to appeal. When the patient got her denial letter 10 days later (for a concurrent care claim that needed an expedited appeal), the instructions on how to request an appeal were different. The carrier still only provided a mailing address to request the appeal and the patient had to call to get a fax number so the appeal request could be expedited. When incorrect information about how to request an appeal is provided, the time frame for requesting the appeal is running out. This is unfair *to the patient as well as the provider!*	Carriers are required to give accurate information to patients on how to file an appeal under existing Maine law. This section just requires the carrier to provide the same *correct* information to providers. See 29 CFR § 2560.503-1 for Claims procedure rules for patients under ERISA law. See 45 CFR § 147.136 for Internal claims and appeals and external review processes for patients who have individual health plans.	This provision does *not* give the patient any greater appeal rights than the patient already has, it merely requires the provider to be given the same *accurate* information about how to appeal so the appeal can be initiated in a timely manner and the patient's appeal right does not expire before they have the opportunity to request a full and fair review. This section does not require the Bureau of Insurance to interfere in the provider-carrier contract. It merely gives the provider (and the patient) an argument for an appeal and a cause of action in a contract dispute if the provider can't find out how to file the appeal within the required time frame because the carrier has provided incorrect information.
Section K – Requires carrier to allow provider to appeal a decision to put the provider on prepayment review.	Providers should be entitled to an appeal of a procedure that has great potential to bankrupt their business. No carrier should have the unilateral ability to place excessive PPR burdens on providers for any or no reason without the provider being given a full and fair review. Providers who have been put on PPR by Anthem feel strongly that Anthem's perception of their documentation and claims	24-A MRSA §4317 (10) requires a carrier to provide an appeal right to a pharmacy provider for an unfavorable audit report as long as the audit, review or investigation is not initiated based on or involves suspected or alleged fraud, willful misrepresentation or abuse.	This does not require the Bureau of Insurance to do anything. It merely requires carriers to provide an appeal right to providers for PPR as a matter of contract. Maine already has numerous laws in place that govern the provider-carrier contract.

	"errors" or "insufficiencies" were indefensible and PPR unwarranted. One provider demanded an appeal and was told there was no appeal right. Anthem could put anyone on PPR any time for any (or no) reason. *Thus the need for this bill!*	***Why should other providers not have the same right?***	
Section L – An amended version of this bill will delete Section L in its entirety.	The Bureau already has to honor the appointment of an Authorized Rep by a patient. However, the Bureau currently requires the patient to fill out the appeal request forms and grievances themselves even when an authorized representative has been appointed. Eliminating this section will not change the patient's right to appoint an authorized representative.	Existing law that allows patients to appoint an Authorized Rep: See 24-A MRSA § 4312 and Bureau of Insurance Rule 850 29 CFR § 2560.503-1 for Claims procedure rules for patients under ERISA law. See 45 CFR § 147.136 for Internal claims and appeals and external review processes for patients who have individual health plans.	
Section M – Prohibits a carrier from putting a provider on prepayment review as retribution for raising contract disputes.	The rationale for this is self-explanatory. Carriers should not be able to use PPR as a punishment for anything. In at least one recent lawsuit, Aetna was accused of using PPR to coerce the provider to refunding money to Aetna for "overpayments" that the provider disputed. The case illustrates how carriers are using PPR to threaten providers, though the case was not certified as a class action for other reasons. (see Association of N.J. Chiropractors v. Aetna, Inc., Third Amended Complaint, U.S. District Court, N.J., filed Dec. 18, 2015).		This provision does not require the Bureau of Insurance to interfere in the provider-carrier contract. It merely gives the provider a cause of action in a contract dispute if the provider is put on PPR for retribution reasons.

April 7, 2021

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

Dear Members of the Committee,

On behalf of our 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association speaks in support of Maine LD 1317, legislation that reduces unnecessary burden and barriers to care.

APTA take seriously our responsibility to advocate for access to timely, appropriate care for health care beneficiaries seeking our services. Payer audits and reviews that place an undue burden on providers ultimately lead to delays and interruptions in necessary care for beneficiaries that impact an individual's potential for their optimal recovery and rehabilitation. These policies do nothing to improve the quality of care and do much to interfere with an individual's ability to receive the appropriate care they are entitled to under insurance laws.

APTA supports appropriate utilization management and reviews that ensure:

- The physical therapist's ability to render patient-centered care using evidence-based guidelines, their clinical judgment, and decision making and full scope of licensure, rather than in accordance with arbitrary policies and protocols.
- Timely patient access to medically necessary services.
- Streamlined administrative processes.

Payer documentation requirements should be consistent with the professional standards established by APTA. It is the position of APTA that documentation standards should focus on clinical reasoning and decision making in the provision of physical therapist services. Consistent with this bill APTA supports peer review of a physical therapist's services only when provided by a physical therapist who possesses an active license without sanctions to practice physical therapy. Peer review should be based on APTA's Standards of Practice for Physical Therapy, the Guide to Physical Therapist Practice, additional APTA documents supporting evidence-based literature, state practice acts, and other jurisdictional state and federal laws relevant to physical therapist services. APTA supports clearly outlined peer-review policies and procedures in all provider contracts or manuals and opposes conducting a peer review without proper prior notice to the provider. APTA strongly encourages payers to provide training to providers before implementing a peer-review policy.

APTA believes this legislation will establish reasonable requirements for audits and reviews that reduce fraud, abuse, and waste without compromising access to care. 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,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President