APTA Maryland

February 21, 2024

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 791– Health Insurance – Utilization Review – Revisions**- SUPPORT**

Dear Chair Beidle,

We represent over 1,800 members and our mission is to foster excellence in the profession of physical therapy by advocating, educating, and promoting best practices to improve the human experience of the diverse society we represent and serve.

APTAMD is part of a coalition to improve patient centered care through legislation titled: ***Health Insurance –Utilization Review - Revisions***

Health insurance carriers engage in a process known as "utilization review," which is a system where the carrier reviews a practitioner's request that a patient receive a certain health care service to determine if the service is medically necessary. The two most common types are "prior authorization," which is requesting approval in advance from the carrier and "stepped care," where the patient must try and fail on other medications (often less expensive) before "stepping up" to another medication.

Senate Bill 791 will improve the prior authorization process by adding transparency, aligning standards, and increasing accountability of the insurers.

The 2021 Report on the Health Care Appeals and Grievances Law (released December 1, 2022) reports that carriers rendered 81,143 adverse decisions (e.g., denials of health care services based on the carrier's decision that the health care service was not medically necessary rather than the judgment of the treating practitioner).

In 2022, the Maryland Insurance Administration (MIA) modified or reversed the carrier's decision (or the carrier reversed it during the course of investigation), 72.4% of the time on filed complaints, up from 70.5% in 2021. This means that in more than 7 out of 10 cases, the MIA ruled that the carrier was wrong, and that the patient should have received the health care service.

The 2021 American Medical Association conducted a survey on the impact that prior authorizations have on physicians and patients and found that:

- 93% of the time physicians reported delays in access to necessary care.
- 82% of the time physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.
- 73% of the time physicians reported that criteria used by carriers for determining medical necessity is questionable - 30% of the time physicians reported that it is rarely or never evidence-based and 43% only sometimes evidence-based.

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APTA Maryland
A Chapter of the American Physical Therapy Association

This legislation would reform prior authorization by:

- Require evidence-based, peer reviewed criteria as the standard of care developed by an organization that works directly with health care providers or a professional medical specialty society.
- Mandate that a physician which made or participated in the adverse decision notify the insured's physician or health care practitioner prior to making the adverse decision and be available to discuss the basis for the denial and the medical necessity of the health care service rather than deny care and then allow for a peer-to-peer meeting after the fact.
- Created a timeline for response by carriers for requests for services or extension of services within 1 working day AND approve requests automatically when a private review agent fails to respond to a request in the mandated amount of time.
- Study the feasibility of a "gold card" standard in Maryland, which would exempt health care practitioners who meet certain standards from prior authorization standards.

The Data –Ultimate Outcome of Physical Therapy Denied Claims

- *13.08% of filed physical therapy claims are denied*
- *66.14% of denied physical therapy claims are appealed*
- *52.34% of appealed physical therapy claim denials are overturned*

The American Physical Therapy Association (APTA) conducted a survey on administrative burden from Dec 2018-Jan 2019. 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.

- 85.2% of providers agree or strongly agree that administrative burden contributes to burnout.
- 74% of respondents agreed or strongly agreed that prior authorization requirements negatively impact patients' clinical outcomes.
- 76% of facilities and private practice owners have added nonclinical staff to accommodate administrative burden.
- 65% of respondents say more than 30 minutes of staff time is spent preparing an appeal for one claim.

If you have any questions, please contact us at 800-306-5596 or aptamd@aptamd.org.

Sincerely,

Roy Film, DPT

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