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February 15, 2023

The Honorable Joseline Peña-Melnyk, Chair
House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, Maryland 21401

RE: House Bill 305– Health Insurance – Utilization Review – Revisions- SUPPORT

Dear Chair Peña-Melnyk,

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 – Reform Utilization Review Techniques**

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 “step therapy,” where the patient must try and fail on other medications (often less expensive) before “stepping up” to another medication.

HB305 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.

This legislation would reform prior authorization by:

1. 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.
2. 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.
3. Study how to standardize electronic systems across all carriers (rather than each carrier having their own system) with the same data points and using a single point of entry, such as CRISP.
4. Study the feasibility of implementing 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 National 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,

Michelle Jamin

Michelle Jamin
Director for Government Relations
APTA Maryland

JD Sheppard

JD Sheppard
President
APTA Maryland

Health Insurance - Utilization Review - Revisions (HB305/SB308) at a Glance



HOW IT AFFECTS THE PHYSICAL THERAPY PROFESSION

Prior Authorization is one type of utilization review

Before a patient can receive physical therapy services, permission from their insurance company is required.



can delay access to medically necessary care by more than 25%



credentials should align when making critical decisions about patient care.



Evidence-based, peer reviewed criteria

is required for pre-auth decisions and developed by an organization that works directly with health care providers or a professional medical specialty society.

Promote delivery of quality healthcare

and access to healthcare services by accounting for the needs of atypical patient population/diagnoses.



allows for deviations from norms on a case-to-case basis.



Rather than deny care and then allow for a peer-to-peer meeting after the fact.



Enhance communication

by alerting the requesting provider before delivering an adverse decision to discuss the basis for the denial.

Standardize electronic systems

rather than each carrier having their own system, using the same data points and a single point of entry.



Save **25%** of administrative time with a standardization of prior authorization forms and processes