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A Chapter of the American Physical Therapy Association

June 17, 2016

Jim Freeburg
Special Assistant to the Insurance Commissioner
Office of the Insurance Commissioner
rulescoordinator@oic.wa.gov

Dear Jim:

On behalf of the Physical Therapy Association of Washington (PTWA), I am providing comments on potential rules to implement HB 1471. I am also providing comments on the prior authorization process in general.

The National Committee on Quality Assurance uses best practice standards to determine quality utilization management processes. These standards should also be applied to prior authorization decisions being made by insurance plans. For example, the following are the NCQA's standards for utilization management that should be considered by OIC in rule-making on prior authorization:

Clinical Criteria for Decisions

- Are criteria and procedures for approving and denying care clearly documented?
- Are practitioners involved in procedures development?
- Does the organization review and revise criteria regularly?
- Can practitioners obtain the criteria upon request?
- Does the organization evaluate the consistency with which the criteria are applied?

Communication Services

- Are staff accessible to practitioners and members to discuss UM issues?

Appropriate Professionals

- Do qualified health professionals oversee all review decisions?
- Does an appropriate practitioner review any denial of care based on medical necessity?
- Does the organization have written job description with qualification for practitioners that review denials of care based on medical necessity?

Timeliness of Decisions

- Does the organization make decisions regarding coverage within the time frames specified in NCQA's standards and guidelines?
- Does the organization notify members and practitioners of coverage decisions within the required time frames?

Clinical Information

- When determining whether to approve or deny coverage based on medical necessity, does the organization gather relevant information and consult with the treating physician?
- Does the organization assist with a member's transition to other care when benefits end?

By far, the most significant barrier to access to care for patients is the timeliness of the authorization after the initial contact for authorization. For example, physical therapists

and their staff are contacting the prior authorization entities many times to initiate treatment for one patient, and those entities retain no evidence of these requests. This is in spite of the fact that each time a physical therapist contacts the company, s/he must give their national provider number, tax ID number and patient ID number. In many cases, the physical therapist must prove (and does prove) that the calls have been made, with no answer from the prior authorization company, but by then, the window of authorization has closed and the entire process must begin again. Meanwhile, the patient is waiting for care.

In addition, the prior authorization entities have little coordination between their own reviewers. For example, therapists who call for authorization get transferred multiple times and have to explain their case again and again to new reviewers, if the original reviewer is not available. This is creating unnecessary work by both the provider and the reviewer. There should be a system to track these calls so that this duplication of effort is eliminated.

Finally, there must be more coordination between the authorization of visits and the provider's plan of care. For example, the physical therapist's plan of care may be four visits over four weeks; but the authorization is four visits over two weeks. To ensure quality care, the therapist's plan of care should take precedence.

We surveyed our members at the end of April regarding their eviCore experience when treating Regence patients over the previous 60 days. We received 127 responses and a compilation of the results accompanies this letter. We can make additional details from the survey results available to you if that would be helpful.

Rule-making to implement HB 1471 is also necessary to further define several provisions in that law. HB 1471 allows a health plan to consult with a health care provider in the same or related filed for prior authorization decisions. PTWA requests a rule that states that consultant must provide his/her credentials on the decision notification.

PTWA also requests further clarification on the definition of "episode of care" established in HB 1471. We suggest that this term be further defined as being limited to the first treating provider or facility on record. This would help when determining a patient's past episode of care from a different provider or facility.

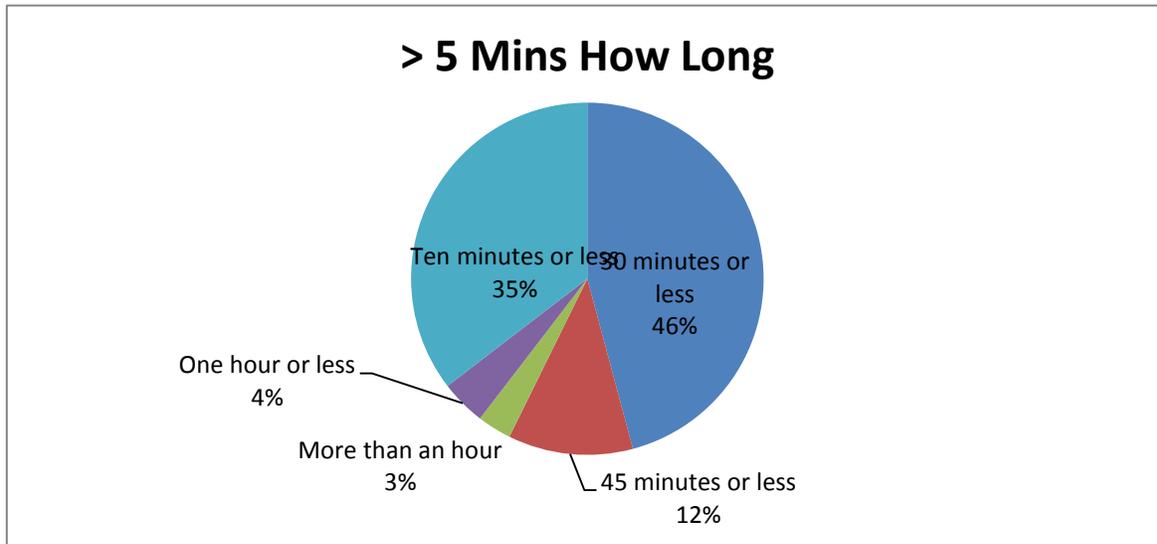
Thank you for the opportunity to comment on rule-making for the prior authorization process. We look forward to working with the OIC on this matter.

Sincerely,

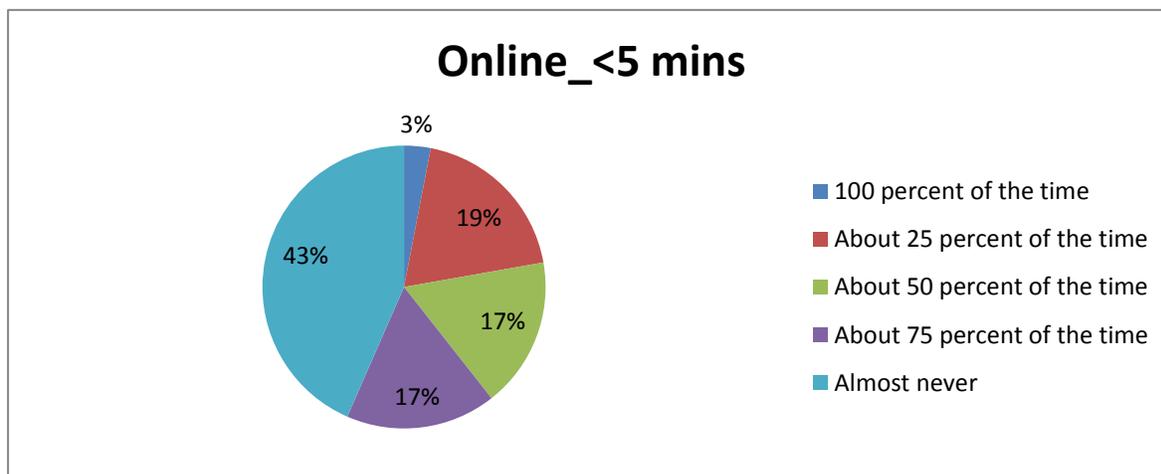
A handwritten signature in blue ink, appearing to read "Erik Moen", with a long horizontal flourish extending to the right.

Erik Moen, PT
President

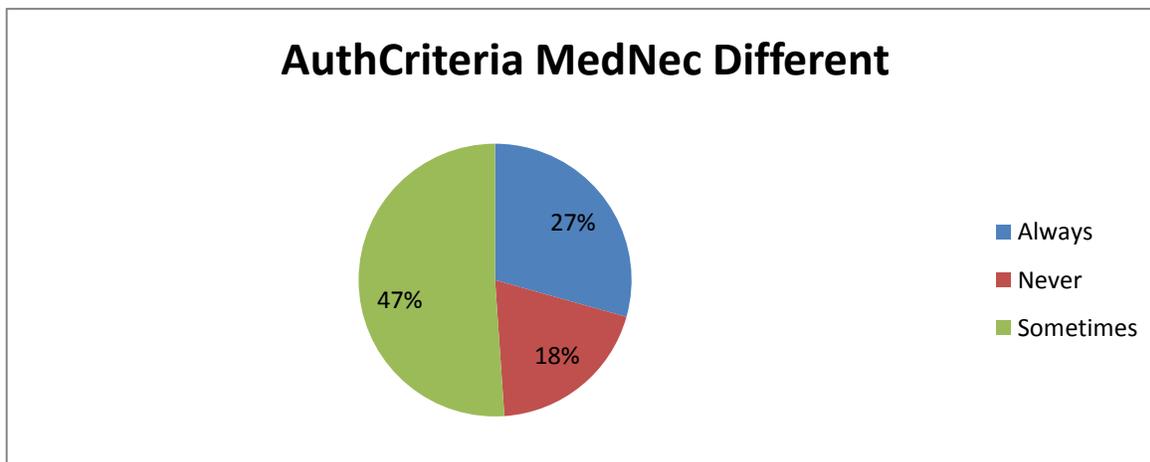
Of the cases that take >5 minutes, how many minutes does it take on average?



Online authorization takes < 5 minutes

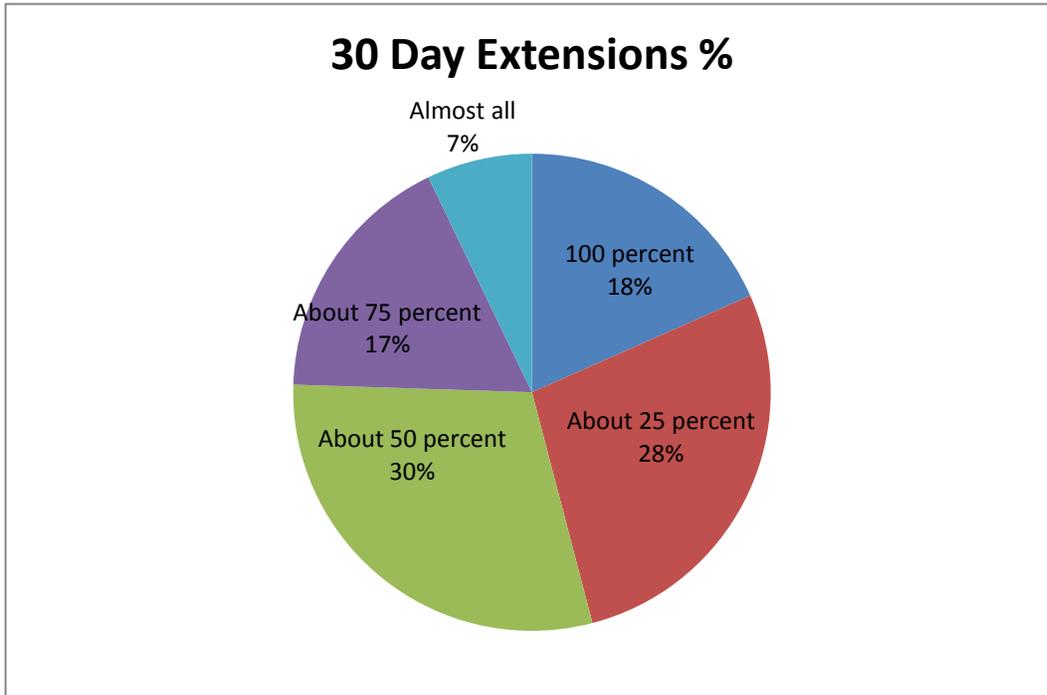


Authorizations with similar scenarios seem to use the same medical necessity definitions

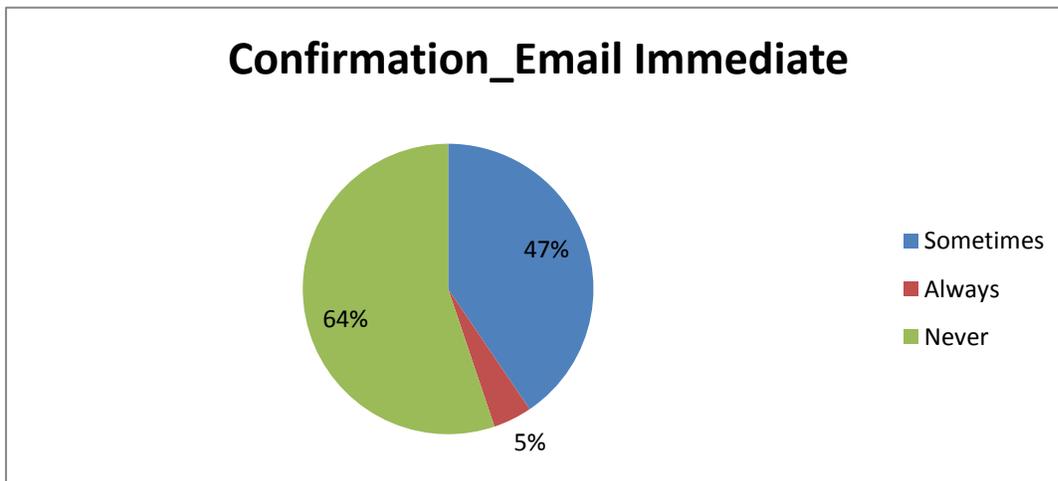


Results of survey sent to PTWA members on 4/28/2016 regarding care provided in last 60 days.
127 responses

What % of cases do not use all approved care within 30 days and require re-authorization?

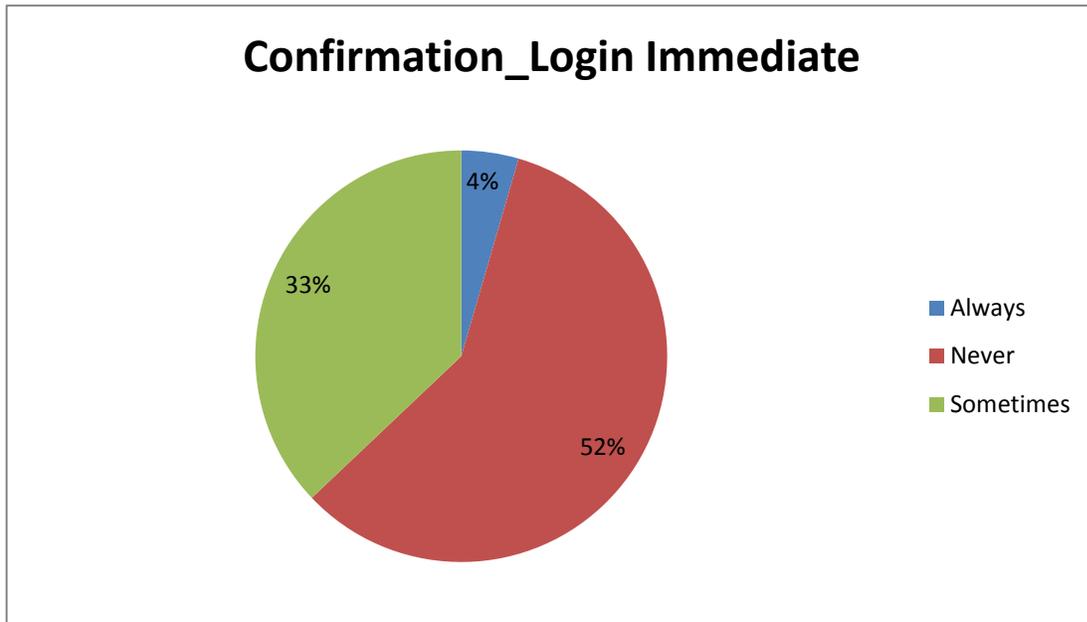


How often is receipt of documentation verified with email?

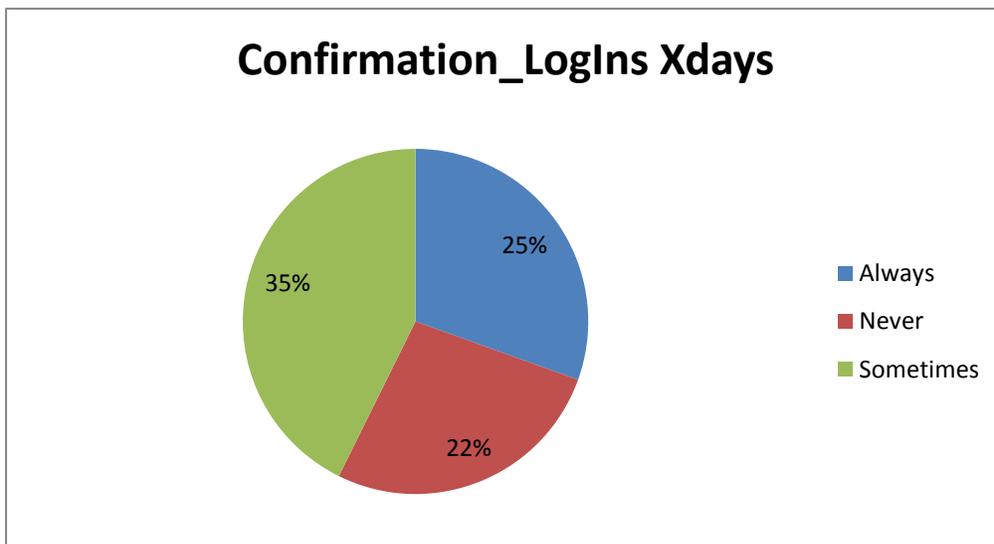


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How often is receipt of documentation immediately verifiable by website?

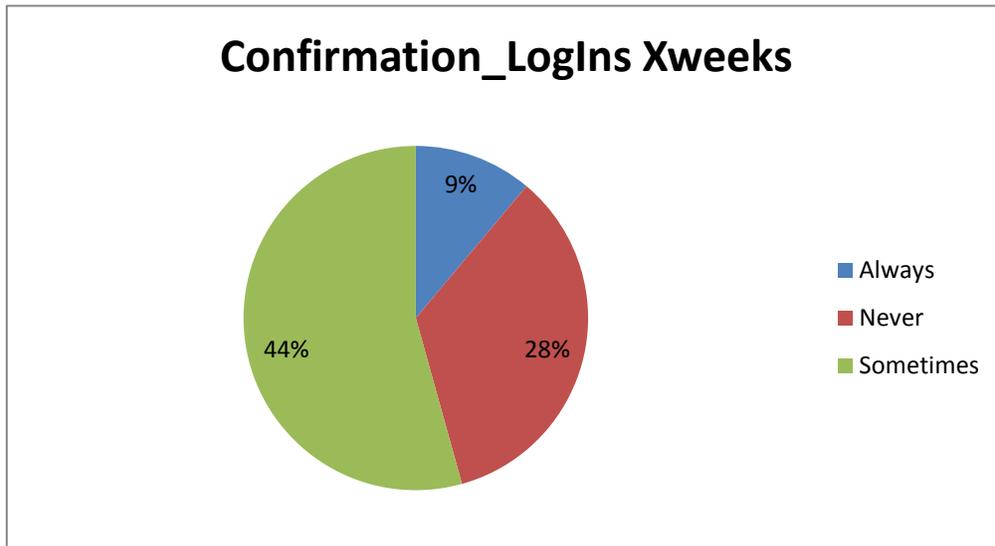


How often is receipt of documentation verifiable on website within days?

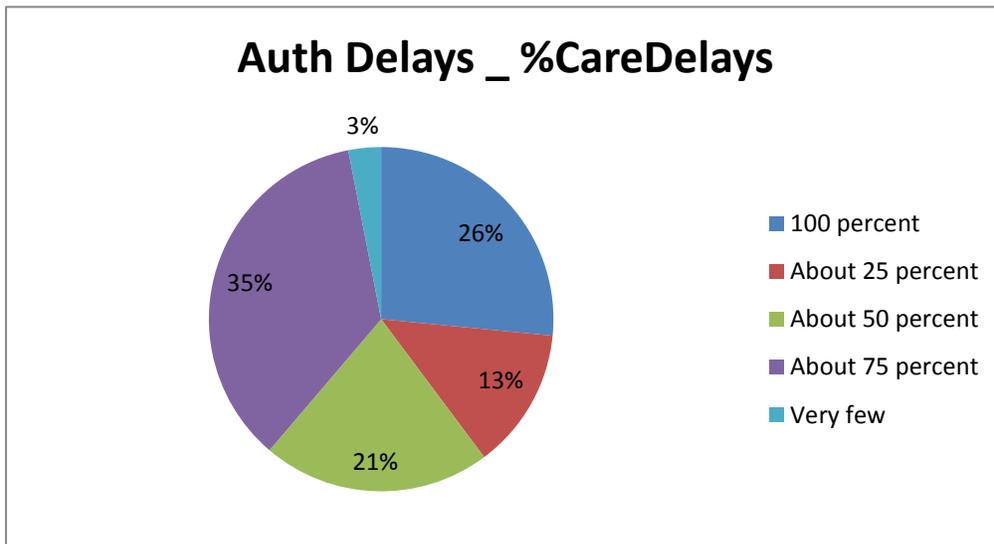


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How often is receipt of documentation verifiable on website within weeks?

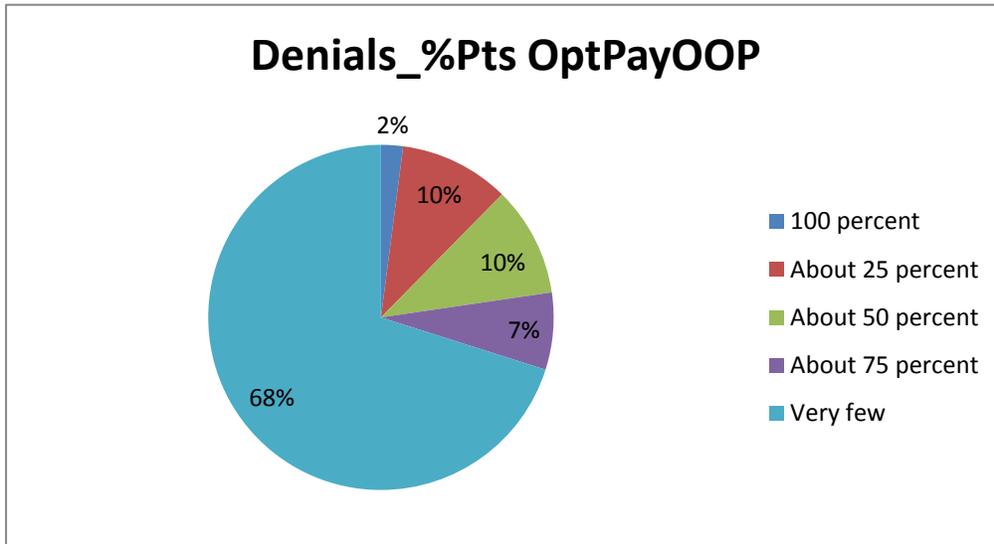


What is the % of patients who delayed care while awaiting authorization?

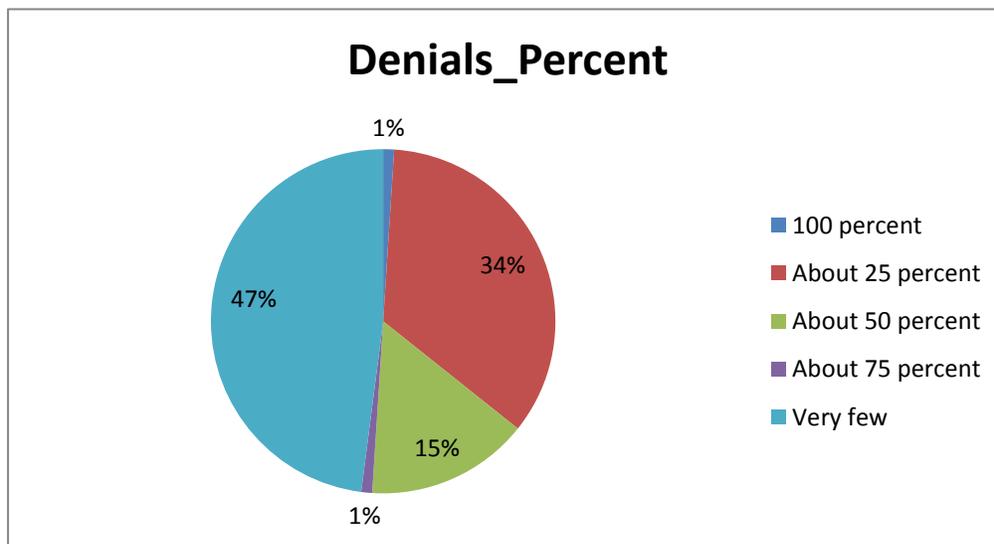


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Following a denial, the % of my patients opting to pay out of pocket?

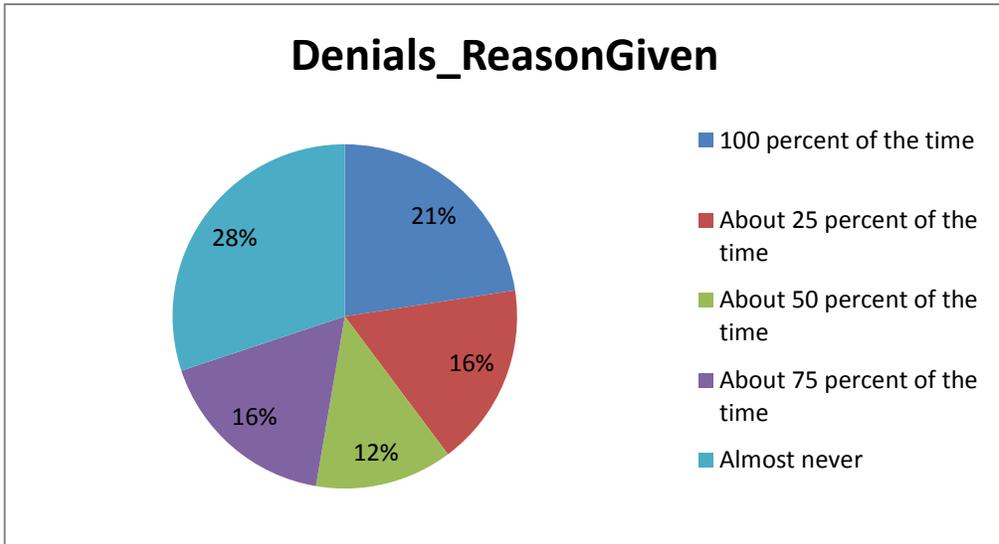


The percent of patients receiving denials

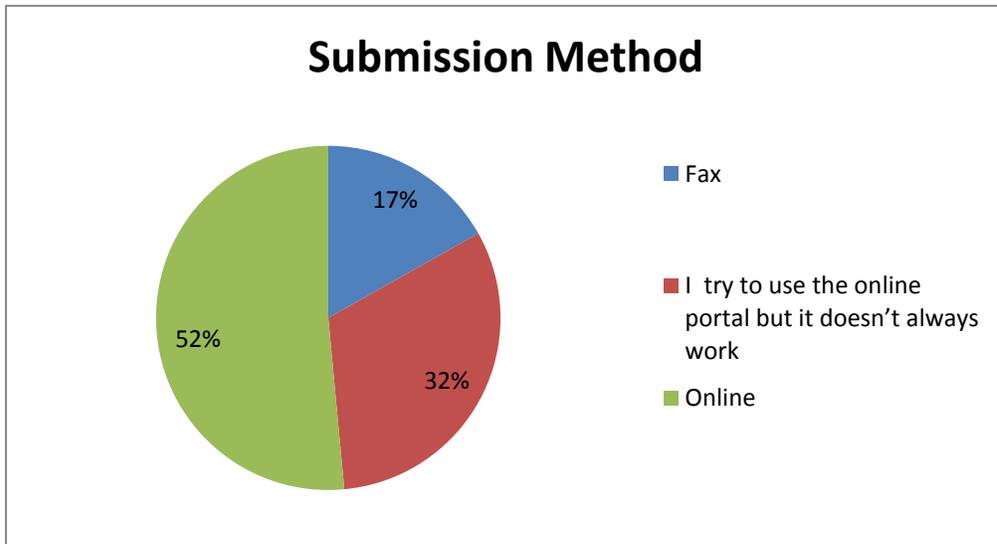


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Of patients denied, was there a denial reason given?



What is your method of submission?



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127 responses

Do you find that the system changes, based on lessons-learned?

