NANCY VANDERMEER

STATE REPRESENTATIVE • 70TH ASSEMBLY DISTRICT

TO: Honorable Members of the Assembly Committee on Health

FROM: State Representative Nancy VanderMeer

DATE: February 16, 2022

SUBJECT: Testimony in Support of Assembly Bill 972

Thank you Chairman Sanfelippo for holding a hearing on AB 972 today. The primary purpose of this proposal is to call attention to some substantive challenges currently being experienced by physical therapy providers throughout the state and subsequently, the delivery of physical therapy care in the commercial marketplace. These issues range from challenges with prior authorization and utilization review processes from insurers, to high co-pays limiting access to service delivery, to hurdles being imposed on those seeking necessary care and helpful services from physical therapy providers. You will have the chance today to hear from physical therapy professionals that can speak directly to some of these issues.

This bill requires and prohibits certain actions related to prior authorization of physical therapy and other health care services by certain health plans. Under the bill, every health plan, when requested to reauthorize coverage, must issue a decision on reauthorization of coverage of a service for which prior authorization was previously obtained within 48 hours or prior authorization is assumed to be granted. Health plans are prohibited under the bill from requiring prior authorization for the first twelve physical therapy visits with no duration of care limitation or for any nonpharmacologic management of pain provided through care related to physical therapy provided to individuals with chronic pain for the first 90 days of treatment.

Additionally, this proposal requires plans to reference the applicable policy and include an explanation to the physical therapy service provider and to the covered individual for a denial of coverage for or reduction in covered physical therapy services and to compensate physical therapy service providers as specified under the bill for data entry of clinical information that is required by a utilization review organization or utilization management organization acting on behalf of a plan. A plan must also impose copayment and coinsurance amount on covered individuals for physical therapy services that are equivalent to copayment and coinsurance amounts imposed for primary care services under the plan. As you can see, there are also provisions in the bill related to transparency for health care providers pertaining to utilization review and management, and prior authorization for services.

As mentioned, today you'll have the chance to hear from health care providers that can speak to the aforementioned issues. You'll also have the chance to hear from some insurance providers and individuals that will surely have some additional information and counterpoints pertaining to this bill and what I've shared. I believe this is a valid issue warranting the proposal in front of you today. However, I want to acknowledge that I think that this is another issue that we've been presented with where there are clearly substantive concerns, but also one where there are numerous factors and challenges, structurally and all throughout the related ecosystem, at the federal level and otherwise, that we're forced to look at in a vacuum, in some ways. I hope that the experts here can help shine some light on this issue and also provide some applicable and tangible evidence to support their perspective.

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Rep.VanderMeer@legis.wisconsin.gov

Tomah Health
TOGETHER IN CARE

2/15/2022

Representative Nancy VanderMeer
State Representative 70th Assembly District
Wisconsin State Capitol
P.O. Box 8953
Madison, WI 53708-8953

Dear Representative VanderMeer,

We are writing this letter in support of AB 972. This bill addresses prompt access to rehabilitation services. In our Critical Access Hospital in Tomah, we see that patients are forced to wait for necessary treatment because of prior authorization delays from their insurance carriers. This delay can cause the patient unnecessary pain, and in some cases, can lead to adverse outcomes when post-surgical care in therapy does not start in a timely manner based on evidence based orthopedic protocols. Longer term pain, restricted motion and strength, and further disability can be the result.

It is not uncommon for the prior authorization process to take up to 20 days for a patient to get access to needed care. AB 972 goes a long way toward reducing pain and suffering and improving short and long term outcomes for our patients. We have seen many situations where the delay in authorization for therapy further delays other care that a person needs beyond the therapy clinic, including further imaging or other specialist visits that may be warranted after utilizing conservative care in therapy as a first step.

The other challenge that we find is that Physical Therapists at Tomah Health are spending valuable time each day on extra documentation steps to receive a limited number of visits that are doled out in small increments through the prior authorization process, when they could be spending this time in the care of patients. Peer to peer visit requirements necessitate our Physical Therapists to take extra time with a representative of the insurance company to justify the plan of care when this information is already detailed in the electronic health record. This is time that could be best spent in direct patient care.

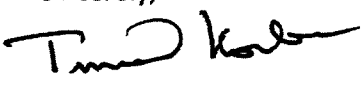
We also find that consumers are misinformed regarding their coverage and how their insurance carrier goes through the approval process for obtaining these visits. These same consumers are then shocked by how long this process takes and are dismayed when their therapy care is delayed with their outcome adversely affected. This process then repeats itself again when there are additional delays when more visits need to be authorized because of the small increments visits are approved in.

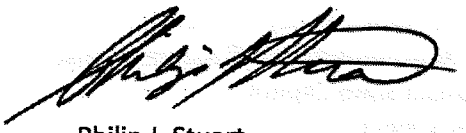
Sadly, many patients that are waiting for rehabilitation to relieve their pain are often treated with opioids. The sooner we can get the patient into treatment, the sooner they will reduce or be able to discontinue pain medications.

We feel that if patients can readily access care without delays following the example that Medicare beneficiaries already have, that outcomes will improve and overall visits will likely be less in the end.

Thank you very much for your important work to address the needs of our patients here in rural Wisconsin.

Sincerely,





Timothy D. Kortbein

Physical Therapist/Rehabilitation Services Director

Tomah Health

Philip J. Stuart

Chief Executive Officer

Tomah Health

APTA Wisconsin
A Chapter of the American Physical Therapy Association

To: Chairman Rep Joe Sanfelippo and Members of the Assembly Health Committee

From: Lynn Steffes PT, DPT APTA-WI Payment Specialist

Date: February 16th, 2022

RE: Support AB 972

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

Thank you for hearing our testimony in support AB 972. I am Lynn Steffes, PT, DPT Payment Specialist for APTA-WI. In my role with our state association, I work with Physical Therapy (PT) providers across the state; some as small as a PT whose mother runs his office in a rural area of Wisconsin and others as large as Mayo Clinic. It is my responsibility to help our members navigate payment and compliance while also serving to represent our interests to third party payers such as Medicare, Medicaid, WI Worker's Compensation, and commercial insurers both local and national and to you our elected policymaker's. It is a role that I am honored to fill since I know the power of physical therapy to diagnoses, treat, and help people manage both musculoskeletal and neurological problems; with the ultimate goal of helping them to live healthy, active, independent lives!

PTs do this without drugs, without expensive imaging, without side effects. PTs focus on careful diagnosis, treatment & education in self-management! As mentioned in earlier testimony, more PT often results in less imaging, less surgery, less use of pharmaceuticals and even less doctor visits! More PT creates better quality of health and life!

In the past 5 years, I have "hit a wall" trying to assist our providers as they navigate increasingly ridiculous prior authorization processes implemented by third party payers. In brief: commercial plans such as Anthem BCBS, United Healthcare, Humana, WEA, and others have found a way to subvert the Medical Loss Ratio Policy implemented through the Affordable Care Act (ACA). The Medical Loss Ratio simply requires that for every dollar spent on insurance premiums (which are always increasing) eighty-five cents must be spent on the care of the patient and only fifteen cents on administration and profit. Unfortunately, a loophole exists that allows them to spend out of the patient's eighty-five cents if they outsource prior authorization. As a result, there has been a proliferation of Utilization Review/Utilization Management (UR/UM) companies that are a subsidiary of the insurers. These entities now turn a profit too! United Healthcare reported 3.3 billion dollars in profit in 2021 Q3 with Optum - their UR/UM subsidiary- providing almost half of their twenty-eight billion dollars in revenue[i].

These organizations are deemed as "quality management" spending by the payers. I can assure that they do little to manage quality of care. Instead, they micromanage the number of visits in small increments and in doing so they delay, deter & deny medically necessary care. Not a week goes by when I do not receive a call or an email complaining about how this process limits provider's ability to deliver needed care.

For 3+ years I have tried to work directly with these payers to create a better, more reasonable solution. I have even flown to Indianapolis with other representatives of our national organization – the American Physical Therapy Association (APTA) to meet with the Anthem and AIM medical directors about our challenges. I have sat on multiple calls both locally and nationally with other payers and their UR/UM subsidiaries. I have finally concluded that legislation is our only alternative. Other states have also moved forward with this process. Ohio, Nebraska, Maryland, Colorado, Washington, Georgia, California and more!

AB 972 is a result of the process getting worse not better despite our best attempts.

AB 972 does not ask that ALL prior authorization be eliminated- the insurers will insist that it is necessary to control so-called "bad actors" in PT. We are only asking for a reasonable process that allows us to deliver the most necessary care and defers prior authorization to extended plans of therapy care. By the way, these same 3rd party payers routinely perform claims analysis by which they can easily identify and perform spot audits to find and manage these bad actors without applying prior authorization to everyone!

AB 972 asks for prior authorization to be administered reasonably in several important ways:

#1 No Prior authorization requirement for the first twelve visits. This will significantly reduce the burden and delays on prompt PT care. It will also save money for the third-party payers and increase the likelihood that extended prior authorizations will be completed in a timely fashion!

#2 No prior authorization for 90 days of PT care for patients with chronic pain- which will enable these patients to have prompt, uninterrupted rehab that is essential to managing pain without reliance or with reduced reliance on pharmaceuticals- especially opioids.

#3 No prior authorization for PT following approved surgeries or procedures where PT is essential to the success of the surgery or procedure to return the patient to function!

#4 When prior authorization for PT is required- responses be required within 48 hours or the authorization is assumed approved. After all, providers are held to strict standards of timely prior authorization submission, or they are subject to denials. Payers should have comparable standards.

#5 When prior authorization is denied, there should be clear and transparent communication to both the provider and the patient including information on the basis for the denial.

#6 When prior authorization is denied, the basis for decisions must have references to their evidenced-based reasoning as opposed to applying irrelevant claims references.

#7 When utilizing UR/UM organizations, evidence should be provided that reviewers who manage these services be properly credentialed in Wisconsin as PTs.

#8 That if the UR/UM company requires the provider to do all the data entry for them over and beyond the extensive evaluations, outcomes tools, progress reports, and daily notes already completed by providers, there be a consideration for the costs of adding that administrative burden. Either increase reimbursement to providers to cover their costs or add payments for providers doing the additional data entry for the UR/UM.

#9 Realign copays for physical therapy services to be consistent with primary care copays rather than specialists. PT is not a onetime consult visit – like a neurologist but instead a multiple visit service that should not be disincentivized by charging unreasonable copays.

I am asking you to please consider supporting this important legislation so that our healthcare dollars are spent on taking care of people not profits!

Sincerely,

Lynn Steffes, PT, DPT

APTA-WI Payment Specialist

REFERENCES:

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ROBERTS
PHYSICAL THERAPY
"Get Moving, Keep Moving, Enjoy Life"

Jacob Brenner, DPT
Carl DeLuca, DPT, OCS
Devin Mattson, DPT, ATC
Brett Roberts, DPT

TO: Chairman Sanfelippo and Members of the Assembly Health Committee
FROM: Brandy Footit, Patient Care Coordinator- Roberts Physical Therapy - Plainfield
DATE: February 16, 2022
RE: Support of Assembly Bill 972

Thank you for taking the time to read my testimony. My name is Brandy Footit and I am a Patient Care Coordinator for Roberts Physical Therapy in Plainfield. **I am writing to you today in favor of AB 972.** I have worked with numerous insurance companies throughout the years and obtained prior authorizations for patients coming in for physical therapy. We strive to help our patients become pain-free and avoid surgeries but we find it challenging for the time we spend sending authorizations and waiting for their response. This wait time can sometimes extend up to several days or weeks depending on whether or not the insurance company requests more information on the care we are providing for our patients.

To give you an example, a patient we have seen recently has WPS insurance that utilizes Magellan as the utilization reviewer. Prior authorization is required after the initial evaluation. The initial evaluation for this patient was on October 29th, 2021. The writer put in the prior authorization on the same day. After checking daily on the portal, we received an update on 11/05/2021 from Magellan that they needed more information. On 11/05/2021 writer uploaded the records on the portal. After checking daily for the second time on the portal, they completed the review on 11/12/2021, which was dated on the letter. We did not receive their response until 11/15/2021 on the portal. This was 18 days after the initial evaluation was completed. The patient had already had five visits by this time, and Magellan only approved them for six visits. The patient was concerned because they had received a denial in the mail from Magellan initially due to their additional information request. The patient did not want to continue therapy until Magellan approved their visits, for which they were already being seen at the clinic. After getting the approved letter in the mail, they discontinued physical therapy because the patient was afraid that Magellan would not approve more. I reassured the patient that we could request more, but they declined us from doing that. The patient could have benefited from physical therapy for ROM and strengthening both shoulders what would have improved their ability to function.

If the prior authorization wasn't required until the 12th visit, the patient could begin physical therapy by reducing symptom irritability and approve outcome for long-term success.

Therefore, I urge the committee to support AB 972.

I appreciate your consideration,

Brandy Footit, Patient Care Coordinator

ROBERTS
PHYSICAL THERAPY
"Get Moving, Keep Moving, Enjoy Life"

Jacob Brenner, DPT
Carl DeLuca, DPT, OCS
Devin Mattson, DPT, ATC

TO: Chairman Sanfelippo and Members of the Assembly Health Committee
FROM: Devin Mattson, DPT - Roberts Physical Therapy – Plainfield and Amherst
DATE: February 16, 2022
RE: Support of Assembly Bill 972

My name is Devin Mattson and I am a doctor of physical therapy and a resident of Stevens Point, WI working as a medical professional within the rural populations of Plainfield and Amherst, Wisconsin. I am a staff clinician and clinic manager at our outpatient physical therapy office who strives to provide high level care and timely service the members of the surrounding communities. **The purpose of this letter is to support the passage of AB 972.** The process that medical insurance companies have created for the use of prior authorizations (PA's) to direct and frankly, dictates the course of care for the patients/clients, negatively impacting those patients requiring medically necessary physical therapy services.

Insurance providers for medical services have increased the usage of third-party payors to determine prior authorizations and approved visits for care utilizing an algorithm-based approach. This approach is overseen by the primary medical insurance but is flawed in one specific fundamental way which is timeliness. To give an example of this flaw, we recently had a patient come to the clinic with acute on chronic right shoulder pain requiring timely physical therapy. He carried WPS insurance who utilizes Magellan as their third-party payor and process for prior authorizations. The patient was evaluated on 10-29-2021 with the evaluation note completed and sent to Magellan that same day. After one week, Magellan reached out for "more information" on 11-5-2021 and subsequently the patient's records were resubmitted for review. After checking daily on the patient's status, his case was finally reviewed on 11-12-2021 and approved on 11-15-2021 for 6 visits. The delay in this process and response by Magellan limited the patient's ability to seek the continuation of skilled physical therapy that he required, and he opted to hold off on PT until the insurance company decided if they were going to cover his bout of care. As displayed within this example, insurance providers require timeliness of submission and thorough documentation, which I provide the same day of service. However, these third-party payers, Magellan in this case, seemingly find it appropriate to delay a response to care for over two weeks. Meanwhile, the person who suffers the most is the patient who is in need of care, yet cannot receive it due to insurance policies/procedures and may have to enter the medical system for ER/urgent care visits, medications, testing/imaging in the meantime. This is just one example of many that we are required to deal with on a daily basis.

In order to combat this current insurance policy and procedure with prior authorizations, I would like to offer a few suggestions to assist with the resolution of the limitations listed above. I first believe that a prior authorization for physical therapy should not be required for the first 12 sessions of care for an acute, non-chronic condition. This would allow for the patient to begin care immediately and assist with timely resolution of their symptoms. Literature shows that the longer symptoms persist, the lower the likelihood is for improvement of the patient's condition. Secondly, I believe that a prior authorization should not be required for those patient's suffering from chronic pain for the first 90 days of care. These patients have typically been thrown all over within the healthcare system and require treatment based on a biopsychcosocial approach which requires frequent PT sessions to begin to break the pain-spasm-pain cycle and improve outcomes. Standardized tests and measures do not appropriately capture this subset of the population and thus algorithm-based authorization systems are faulty and flawed for this patient population. With the opioid epidemic and pain management based options offering limited success and the development of addictions with this population, I

feel it best fit to allow a skilled physical therapist to treat these patients without the worry of limited visits or delay in treatment.

I thank you for hearing my concern regarding the prior authorization process utilized by many insurance companies as this greatly impacts the health and well-being of our citizens requiring timely and highly effective physical therapy services. **I ask the committee to support AB 972 as this change is needed to foster improved care, without unnecessary delay, to our community and its constituents.**

Sincerely,

Devin Mattson, PT, DPT, ATC

ROBERTS
PHYSICAL THERAPY

"Get Moving, Keep Moving, Enjoy Life"

Jacob Brenner, DPT
Carl DeLuca, DPT, OCS
Devin Mattson, DPT, ATC

TO: Chairman Sanfelippo and Members of the Assembly Health Committee
FROM: Carl DeLuca, DPT, OCS Roberts Physical Therapy – Wisconsin Rapids
RE: Support of Assembly Bill 972

I am a Doctor of Physical Therapy and a member of the Wisconsin and National Physical Therapy Associations. I work for Roberts Physical Therapy in Wisconsin and treat patients within the Central Wisconsin region.

I am writing in support of the 2022 Assembly Bill 972, relating to prior authorization for coverage of physical therapy and other services under health plans. Three reasons I support this bill are to increase the speed of reauthorization decisions, elimination of prior authorization for physical therapy provided to chronic pain patients for 90 days, and any denial or reduction in approved care must reference policy and include an explanation.

First, authorization decisions currently have no deadline for return. Even if a decision is made for more visits, that authorization can often take over a week. During this time, the patient is not getting his/her needed therapy and can regress on the progress already made. A quick return of an authorization decision would allow patient progress to continue without delay.

Secondly, physical therapy for patients in chronic pain is not a quick process, taking 90 days or longer. For example, I just worked with a patient who was making good progress in a month of therapy but was not approved for more visits. Allowing patients with chronic pain to continue physical therapy for at least 90 days, will greatly increase the chance they reach their goals.

Finally, we often receive denials with little explanation, no explanation, or a nonsensical explanation. For instance, one of the most common explanations we receive is "patient can continue physical therapy with a home exercise program only." We even get that denial for disabled patients who are not capable of exercising independently or aquatic therapy patients who do not have pool access outside of therapy. This shows that the reviewers are even not reading all authorization requests. If insurances deny our services, a valid explanation should be provided.

Thank you for reading my thoughts on this matter. In order to improve patient care for physical therapy patients in at least the reasons listed above, please support the 2022 Assembly Bill 972.

Sincerely,

Carl DeLuca, DPT, OCS

Carl DeLuca, DPT, OCS
Roberts Physical Therapy – Wisconsin Rapids

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February 15, 2022

Dear Representative Murphy,

As a practicing Physical Therapist (PT), a small business owner, a former member of the Physical Therapy Examining Board and a consumer of health care I encourage your support of AB972.

Physical Therapy is a direct access service in the state of Wisconsin. PTs are highly-educated, licensed health care professionals who help patients cope with pain and improve their mobility and function. We employ a customized, cost effective, interactive and conservative treatment approach. Prompt and unencumbered access to Physical Therapy can discourage overuse of drugs and help to prevent unnecessary diagnostic imaging and surgeries.

PTs subscribe to the core caregiver tenet of "Do No Harm." During my 37 years of practice, I have advocated for my clients by choosing to work with their third party payers. Unfortunately, the commercial health insurance industry has metastasized to the point where it currently poses a threat to the health and well-being of my patients. Their cumbersome policies, promotion of terms such as "prior authorization" and "approved visit" and ever-increasing premiums, co-pays, co-insurance and deductible amounts have had the consequence of blocking access to medically necessary care.

Over the course of the past 16 years as a small business owner, my office staff and I have had to spend more and more time "jumping through hoops" created by insurance companies and their proliferating intermediaries. Countless unproductive hours have been spent on hold waiting to talk to a insurance representative only to obtain contradictory information. Not only do consumers suffer but the viability of my business and the efforts of other entrepreneurs are compromised.

Having served for seven years on the PT Licensing and Examining Board, I can confidently attest that the Physical Therapy professionals in the state of Wisconsin are a trustworthy and ethical bunch. For payers to try and justify additionally burdensome draconian policies and micromanagement tactics based on mythical accusations of widespread fraud is disingenuous at best.

I recently had occasion to shop around for family healthcare coverage and spoke with a leading local insurance broker. Imagine my surprise when the agent admitted he was shunning any commercial health insurance options in favor of a faith-based "health sharing" plan. How telling is it that the salesperson no longer believes in the product?

In summary, commercial health insurance companies have developed convoluted procedures consistent with a "guilty until proven innocent" tenet. It is critical to stand up against payers who aim to put profits ahead of people. Supporting AB972 is a necessary next step in regaining consumer freedom, supporting small businesses and limiting the harm caused by misguided third party payer policies.

Sincerely,

MSPT

Mark Shropshire PT

To whom it may concern,

My name is Nicolas Olson-Studler and I am a Physical Therapist who works full-time in Cedarburg, Wisconsin at an Outpatient Hospital-Based clinic (The Orthopaedic Hospital of Wisconsin). Our team of skilled physical therapists regularly evaluate and treat patients in our community that have a variety of insurances, including but not limited to Medicare, Medicare Advantage, and commercial insurances. Over the past several years we have noticed a sharp increase in the number of pre-authorizations required for our patients to receive Physical Therapy services. Often these pre-authorizations result in limited and insufficient insurance coverage for our patients, who then cannot afford all the physical therapy they need (deemed medically necessary by the Physical Therapist), regardless of the diagnosis or level of functional mobility impairments. This routine practice by commercial insurance companies to deny justified physical therapy services has resulted in modified, delayed, and insufficient PT plans of care for our patients.

For example, I was treating a 62 year old woman who had undergone a bilateral total knee replacement, a rehabilitation process that requires 3 months and 20 PT visits on average to fully recover. Anthem Blue Cross Blue Shield (AIM) had only granted 9 visits initially with pre-authorization. So after the pt had completed her 9th visit on the 3rd week of therapy, I submitted for re-authorization, which took AIM 3 weeks to review before denying and closing the case. Not only was the patient still in debilitating pain and lacked the ability to perform basic ADLs without assistance, but she also was unable to be seen in the clinic for therapy since she "couldn't afford PT out of pocket" while the insurance company decided the fate of her recovery for her. It took weeks for me to call the insurance company numerous times to fight on behalf of the patient for additional visits in order to complete her rehabilitation process.

This is unacceptable that this patient, and many others in our clinic in similar situations, whom was left in the lurch while her insurance company decided how much therapy she deserved or needed, despite me and her orthopedic surgeon providing ample evidence for medical necessity for Physical Therapy treatment. Therefore, I support Assembly Bill 972 (An Act to amend 632.85 (title) and 632.85 (3); and to create 632.85 (1) (d) and 632.851 of the statutes; Relating to: prior authorization for coverage of physical therapy and other services under health plans.) to help reduce the burden on the patient and Physical Therapist in providing adequate healthcare services.

To address the burgeoning opioid epidemic and decrease administrative costs associated with providing physical therapy services, the following Utilization Review and Management (UR/UM) standards should be enacted in Wisconsin, including the patient-Friendly UR/UM Standards: 1. Prior authorization shall not be required for the first 12 physical therapy visits with no duration of care limitation. The first authorization for care would occur for visits after 12. (FOTO data).

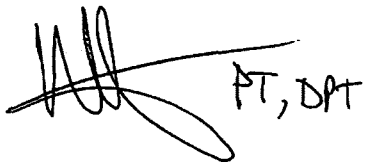
Large insurance companies, such as United Health Group, Anthem BCBS, CVS Health, and Humana, have all profited during the pandemic, while the average healthcare consumer (our patients) have suffered from reduced access to essential and cost-saving physical therapy services.

I urge you to consider my unique situation in which I am able to care for my patients face-to-face, hear their story, listen to their daily struggles with pain and mobility dysfunction, then help lift them out of despair to a more purposeful and limitless life. Meanwhile, these certain insurance companies many miles away try to decipher each individual patient's story and needs through CPT and ICD-10 codes. It is impractical and unfair for these companies to determine how much healthcare a person needs, something that a trained healthcare professional should be recommending instead.

Please help me make change on this topic: reduce the need for pre-authorization and re-authorization from commercial insurance companies regarding outpatient physical therapy services.

Please reach out to me to discuss this urgent topic.

Nicolas Olson-Studler



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2/14/22

To whom it may concern,

My name is Janet Koehler, My father is Thomas Jungwirth. I oversee the health care giver for my father who is 82 years old. Tom is widowed due to COVID 19. I have some significant concerns regarding my father's Insurance based Medicare plan. He is being mistreating him in terms of refusal to allow for necessary approvals for provision of physical therapy services.

My father has difficulty with strength, balance, and pain. Pain issues include chronic pain with leg pain, knee pain, and bilateral foot pain. I seen that regular attendance in physical therapy over the last three years has enabled him to remain independent in his condo and enables him to remain active in the community for socializing with his friends and attending exercise groups at cardiac rehabilitation, as well as weekly religious services. Recently, the insurance company, in this case Network Health Medicare, has been limiting his access to Physical Therapy. My father has developed difficulty walking, and moving around due to pain, weakness and immobility. This concerns me greatly as he currently requires the use of a wheeled walker to get around, whereas when he is functioning at his best, he requires a cane support only-and in fact can walk around with no assistive device.
There is no reason for why my father shouldn't have access to physical therapy services that are under the guidance of the doctors of physical therapy. The Doctors of Physical Therapy recommend a series of treatments that would include 14 to 20 visits in order for him to regain his strength, balance and pain control to enable him to remain independent. However, over the last year they have authorized fewer sessions that recommended or needed for him to remain strong and independent. This is despite having significant clinical documentation from the Doctor of Physical Therapy in regards to his balance,gait, pain, and coordination problems. We even went to lengths to obtain a letter of medical necessity from his primary care provider. This does not help the situation. The insurance company may authorize a couple more sessions-typically 2 or 3 after initial 4-6 visits with a reauthorization. When reauthorization is requested, more than half of a given physical therapy session is dedicated to collecting data to satisfy the reauthorization request with paperwork. This obviously limits the impact that the few physical therapy sessions have on his well being and recovery.

It is my belief that the insurance company is only in this to gain more profits when they deny my father the necessary physical therapy for him to remain independent. I worry that further denial of services will lead to long term complications. If my father loses his independence by the insurance company denying him necessary Physical Therapy he will have detrimental effects that include: inability to maintain his balance, loss of strength, reduced coordination, increased pain levels, social isolation away from his faith community and friends, worsen his chronic health conditions (kidney disease, hypertension, heart disease, depression and diabetes. Ironically as his health status deteriorates his medical care will cost the insurance company infinitely more money than the inexpensive services that physical therapy provides.

In short I am frustrated and rather disgusted that the insurance company would continue to limit his access to necessary procedures without any opportunity for significant input from either his primary care doctor or the doctors of physical therapy. It's my hope that the state of Wisconsin will protect the rights of those who are vulnerable in this situation and enable adequate coverage for necessary services to avoid further disability and potentially overburdening family and government resources with eventual nursing home placement where if individuals like my father cannot maintain their independence with the judicious use of physical therapy intervention.

Please feel free to reach out to me at the following for any thoughts and concerns regarding this. I applaud your efforts in supporting whatever laws we can to protect the interests of the patients and on behalf of the insurance company on the backs of individuals who have paid into Social Security their whole lives. I can be reached at: 920-463-0008. Alternatively, you can email me at Horsedreamer@new.rr.com. I thank you for your time and attention in this matter and look forward to your response.

Respectfully,

Janet Koehler

Janet L. Koehler
3111 Sawyer Creek Drive
Oshkosh WI 54904
Health care provider for my father Thomas Jungwirth.

February 15, 2022

Hello,

As a practicing Physical Therapist with Hand Therapy certification and with 29 years' experience I have seen an increasing trend of insurance companies such as Anthem, Aim, UHC OPTUM , Security Health Plan-Evicore and UR/UM Entity causing delays or denials that are impacting much needed care. There are numerous patient examples that can be described.

I often see patients following traumatic injuries that can include snow blowers, table saws, lawn mowers, falls and auto accidents. The need for consistency of care for these patients is paramount to optimize their outcomes. One patient was limited to 2 visits prior to requiring reauthorization. Each second visit, a reassessment needed to be completed. The patient would schedule 40-50 min treatment sessions. Reassessments can take up to 15-20 min of each appointment time given how much documentation/objective measurements are required. The need for such frequent reassessments would limit the amount of hands-on time that could benefit the patient. On top of that, the turn around time for authorizing additional visits was 7-10 days! Of course, the patient then would have 2 therapy sessions and then must wait often 1 ½ weeks before her next session. Any progress made with two consistent visits was ultimately lost or delayed with minimal carry-over from the previous visit. The patient herself was her own strong advocate as she would frequently contact her insurance provider to expedite the process, but this was to no avail. This was a very frustrating and arduous process for both the patient and for me as her clinician. At times, I have felt that in my 29 years of experience that the insurance companies act as if they are in a state of power over patients and medical providers which often feels like harassment.

Overall, insurance companies are contributing to the cost of managing health care, by demanding more frequent and unnecessary progress reports from therapists, demanding time-consuming peer-to-peer reviews, and most importantly causing delays in patient care that can impair ultimate patient outcomes and costly additional surgeries.

Respectfully submitted,

J Michelle Mueller, PT, CHT

J Michelle Mueller, PT, CHT

February 11, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I feel compelled to reach out to you to support **Assembly Bill 972**. I witness patient dissatisfaction and frustration with the authorization process routinely, as well as less than ideal outcomes due to delayed responses and piecemeal approvals.

A recent example I can provide involves a high-risk pregnancy patient. The patient began therapy 25 weeks into her 5th pregnancy. She is currently carrying multiples, has a history of pre-eclampsia and is under the care of a maternal fetal medicine specialist. For the pregnancy population, even in a non-high-risk patient, patients typically require skilled care throughout the course of pregnancy and often into the early postpartum period due to the significant changes the body goes through and the impairments and functional limitations this can cause. Pregnancy patients do not improve in the same way as non-pregnant patients due to the progressive nature of pregnancy. This is a more complex patient population and there is more unpredictability and variability in total visits required as well as patient progress. High-risk pregnancy adds additional complexity with more variables that must be monitored.

AIM only authorized 4 visits for this patient initially which would never be adequate for her diagnosis and status. She has been seen for the evaluation and 2 follow-up visits and already on the 3rd follow up visit we will have to spend time taking measurements to request more visits when we would not expect significant improvements yet. Then we will have to wait to see her until further visits are approved which would delay care and possibly cause her pain to worsen. She will likely require skilled care anywhere from 2x/week to 1x every other week until her delivery in May.

In addition, the measures AIM requires for visit requests are not always applicable or meaningful depending on the patient. For example, with this high-risk pregnancy patient we are not going to improve her range of motion during pregnancy and therefore would waste time measuring it for a progress note. Similarly with strength, while we are addressing strength we are doing so in a more functional way and again spending time performing manual muscle testing is not a meaningful way to show her progress or need for continued care.

Physical therapists have doctoral degrees in their field and should be given the respect and autonomy to determine the number of visits required for patients to achieve their goals and at the very least what measurements show patient progress and or/need for further therapy.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Stephanie McCabe PT, DPT
Physical Therapist, Prevea/HSHS
Green Bay, WI

TO: Chairman Sanfelippo and Members of the Assembly Health Committee

FROM: Angela Webb-Buffington, Business Office Manager

DATE: February 16, 2022

RE: Support of Assembly Bill 972

My name is Angela and I am the Business Office Manager/Biller for Nissenbaum and Schleusner PRO Physical Therapy, LLC in Middleton, Wisconsin. As the person submits the requests on behalf of the clinic for prior authorization, I have to express how tedious it is when the clinic has to request for authorization for physical therapy. Often times, the clinician is requesting 10-12 visits and the insurance company's UR/UM approves ½ or less. Then, requesting additional visits only to get 2 or 3 visits approved at a time, when the clinician knows that it will take more visits than that to progress the patient through their plan of care. Every time we need to submit for authorization, patient care has to be put on hold in order to confirm we can get the authorization in place. This then creates a problem with scheduling because the patient has been scheduled out for their proposed plan of care. There are also delays in care when the clinician has to do peer to peer review in order to explain what is already be sent in notes and the request for visits. This takes up time of both the clinician to do the peer to peer review (during valuable patient care time) and myself to set up the peer to peer call.

Patients get upset when there is a gap in treatment when they are told their plan has X number of policy visits but then we have to tell the patient they can no longer come for physical therapy because it was not approved by their insurance. If the plan has X number of visits the patient should be allowed to use those visits without prior approval.

In addition, claims often times need to be resubmitted with proof of authorization in place. After receiving a denial that no authorization is in place. This is costly due to have to resubmit claims or appeal decisions when it is clear there was an authorization in place through the insurance company's third party UR/UM department.

Each company's Utilization Review and Management standards appear to be different. I would respectfully request to have consistent standards to follow when it comes to UR/UM for physical therapy authorizations.

Sincerely,

A. Webb-Buffington

Angela Webb-Buffington

6649 University Avenue, Suite 100
Middleton, WI 53562
(608) 841-1290
www.proptgroup.com

Amy Reiter

From: Naas, Ashley E <Ashley.Naas@hshs.org>
Sent: Tuesday, February 15, 2022 8:01 AM
To: Rep.Sanfelippo@legis.wisconsin.gov; aptawi@aptawi.org; Rep.Behnke@legis.wisconsin.gov; Rep.Tauchen@legis.wisconsin.gov; Rep.Shelton@legis.wisconsin.gov; Rep.Steineke@legis.wisconsin.gov; Rep.Sortwell@legis.wisconsin.gov; Rep.Steffen@legis.wisconsin.gov; Rep.Macco@legis.wisconsin.gov; Rep.Kitchens@legis.wisconsin.gov
Subject: Support Assembly Bill 972

February 14, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I encourage your support of **Assembly Bill 972.** I, like many other Physical Therapists, have had numerous cases of struggling to attain medically necessary authorization for PT visits.

An example of this that recently occurred was an elderly individual suffering from chronic low back and hip pain with a multitude of other conditions and severe degenerative scoliosis. 9 visits were initially authorized through EVICORE, then 3 more with a submitted progress update. During this, another progress assessment was completed leading to a denial of further visits with an option to complete a Peer to Peer review. With this review, a final 2 visits were authorized despite the patient continuing to have ongoing functional limitations, pain, and the requirement of hands on and verbal feedback for successful and safe performance of his home exercise program. In addition to these visits, the chronicity of his symptoms often lead to fluctuations in his progress on a day to day basis often making us hope that he was in a "good" day when needing to perform a progress note due to the requirement of proving significant progress in order to authorize more visits. Prior to authorization of the final two visits, the patient also had a week where his visits had to be canceled and he was unable to attend PT due to the initial denial. Though the patient was not comfortable continuing on his own, he was discharged after his last authorized visit.

The patient's son recently reached out to me to update me that his Dad, the patient, had a fall within his home just 2 weeks after his unnecessary discharge from PT and suffered multiple rib fractures. I am in strong belief that if he would have been able to continue the appropriate strength and balance progression, this may have been prevented.

I feel we are failing these patients by limiting medically necessary care to an "algorithm" that decides how many visits these individuals are allotted. The key word being, *individuals*, where all episodes of care should be unique to each patient.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Ashley Naas PT, DPT
Prevea Therapy Institute – Allouez
1821 Webster Ave
Green Bay, WI 54301
(920)272-3380 x75656

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Fax: 414-281-3435
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3906 S. 27th Street
Milwaukee, WI 53221

To Whom it May Concern:

When I opened Physical Therapy of Milwaukee and Physical Therapy of Wales to provide one of a kind bilingual and bicultural physical therapy services, I quickly realized how time consuming and difficult it was going to be to provide timely service while abiding by the utilization review guidelines. Our staff was busy educating patients on how to heal their joint pain and muscular dysfunction in addition to spending an equal amount of time discussing the utilization management guidelines we are forced to follow. Many patients didn't understand why we couldn't provide treatment at the first visit and our inability to schedule their next appointment until a formal authorization was received.

Some examples of how the utilization review process has affected patient care are:

1. It has limited our ability to deliver medically necessary care at the first visit
2. It has caused unnecessary delays in providing follow-up care
3. It has caused patients to terminate services early

Besides the increasing cost of staffing to keep up with data entry and learning various submission methods, our clinic has felt the frustrations of not giving patients the care they need or are allowed with the terms of their policy. Frequently, patients have an extensive amount of physical therapy benefits but are authorized 3-8 visits at a time. Depending on various healthcare factors affecting patient success, we normally can see functional improvements within three to four weeks. Generally, we can reach a short-term goal while consistently seeing a patient 2x3 weeks – that is already 6 visits used. We have seen the authorization process take at best 48 hours and at worse 1 month! We pride ourselves on being a full-service clinic providing a one-on-one patient care approach.

Utilization review processes are leaving the already vulnerable patient, that seeks physical therapy due to chronic pain, joint pain, or post-surgery with added barriers to seek the healthcare they should be afforded under their insurance policy.

I urgently request your support for this bill.

PT, DPT

Dr. Sylvestra Ramirez PT. DPT. MWH. CEAS
Clinic Founder: Physical Therapy of Milwaukee and Physical Therapy of Wales
www.yourptm.com
Phone: 414-281-3444
Fax: 414-281-3435

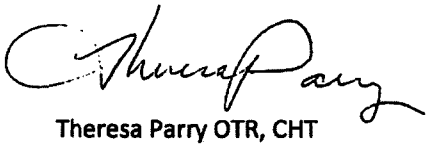
2/13/22

To whom it may concern:

As a practicing Occupational Therapist in Appleton, WI with 10 years experience I have seen an increasing trend of insurance companies such as Anthem, Aim, UHC OPTUM , Security Health Plan-Evicore and UR/UM Entity causing delays or denials that are impacting much needed care. There are numerous patient examples that can be described.

Insurance companies are contributing to the cost of managing health care, by demanding more frequent and unnecessary progress reports from therapists, demanding time-consuming peer-to-peer reviews and most importantly causing delays in patient care that can impair ultimate patient outcomes and costly additional surgeries.

Respectfully submitted,



Theresa Parry OTR, CHT

February 11, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I am writing to encourage your support of **Assembly Bill 972**. Its contents significantly impact the day to day operations at our outpatient physical therapy clinics. Colleagues that are doctoral-level trained are taking repeated clinical measurements and composing extensive documentation, in attempts to get physical therapy visits authorized. Then it is not uncommon for the AIM or EVICORE systems to take 1-3 weeks to respond, which often results in delays in patient care and unacceptable cancellations of their therapy appointments while we wait for the insurances decision. If this authorization is denied, it is not uncommon for clinicians to attempt peer-to-peer or medical review phone calls with the insurance company that may involve canceling multiple patients' scheduled appointments to accommodate the time required. Often times, clinicians will be given certain timeframes by the insurance company that the insurance adjuster will give them a call, that the therapist will have to block during patient care time limiting access to be able to help another 1-2+ patients. Not only is this valuable time taken away that could have been used toward patient care, but it is all too common for these phone calls to never take place or be rescheduled to a later date due to the insurance adjusters either forgetting or only being on the phone with therapist for 5 minutes out of the hour timeframe they say they may call during. This is incredibly rude, inconsiderate, and a waste of the clinician's time and is valuable time that was taken away from patients that could have been treated. In the healthcare system that I work in, it is not uncommon for our entire division to have 300-400 patients on a waitlist at a given time looking to receive care. Having our staff put forth extra and unnecessary work just to jump through hoops for authorization is incredibly time inefficient and is creating more backlog and wasted appointment times, further delaying care for multiple patients.

Patients that have insurance managed by AIM or EVICORE are very frustrated and all too often just stop coming to therapy all together because of the hassle the insurance is causing them to receive necessary care to get back to their lives, their families, and their jobs. Their physical therapy care is being dictated by someone separate from their medical team, despite having a policy that relays that they have outpatient therapy benefits. This is deceiving and unfair. It seems these insurance companies are more interested in making the patient and healthcare providers jump through multiple hoops until they get frustrated enough and just give up, rather than authorizing these medically necessary visits and trying to prevent further, more expensive medical care that could be avoided with proper physical therapy care.

Please support Assembly Bill 972.

https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Adam Wied PT, DPT

Physical Therapist, Prevea/HSHS

Outpatient Therapy Facilitator

Green Bay, WI

Amy Reiter

From: Donald Olsen <olsen377@gmail.com>
Sent: Monday, February 14, 2022 1:41 PM
To: aptawi@aptawi.org
Subject: HR 972 and senate bill 972

My name is Donald Olsen, I am a practicing physical therapist and a constituent, living in Ozaukee county.
This bill addresses the prior authorization requirements of insurances and the impacts it has on access to medically necessary physical therapy Several patients in our private practice over the last several years have run into delays and limitations in authorizing medically necessary physical therapy.
Often times these delays in authorizations result in a decline in function and setback in the patients condition. If services are denied there is often no reasonable explanation.
Patients are then forces to pay fully for care out of pocket or forgo the services needed if unable to afford the treatment costs.

We have also have had to deal with a formula that offers declining visits allowed with each authorization request that involves significant time by the provider to present the case for allowing further visits. This takes away from treatment time with the patient and creates another administrative burden for the physical therapist.
These delays in authorizations have at times taken several days or weeks.

While insurances are posting record profits as physical therapists we see constantly declining payment for our services and more restrictions by insurances for patients attempting to access or services.

Physical therapy has been proven to be a cost effective and effective means to successfully treat pain and return people to their normal functions without the use of opioids and pain medication. Yet insurances continue to decrease reimbursement for physical therapist services and restrict access for clients seeking our services, and increasing the administrative burden of providing physical therapy care.

I urgently ask you to support this legislation.

Respectfully,

Donald Olsen PT, EdD,OCS
8679 Pleasant Valley Rd.
Saukville, WI. 53080
414-841-8871

Jessica M Stotz, PT, DPT, OCS
314 Service Road
Spooner, WI 54801
jessica@ptwellness.net

Re: Wisconsin Assembly Bill 972

February 14, 2022

Esteemed legislator,

As a physical therapist practicing in Spooner, Wisconsin, I would like to bring attention to the Assembly Bill 972 addressing prior authorization for physical therapy services. Throughout my seven years of practice in the physical therapy profession, I have seen time and again patients who have received less than optimal care because of financial constraints related to insurance prior authorization limitations. These prior authorizations are often based on algorithms related to standardized care patterns, not taking the patient's individual needs into account.

Specific examples include:

- Rotator cuff repair rehabilitation prescribed by the physician for 12 weeks at 2-3 visits weekly (24-36 total visits), limited by prior authorization to 12 visits per year, with no ability to appeal.
- Achilles tendinitis responding favorably to physical therapy within the six initially authorized visits, but then stalled by authorization that consistently took 2 weeks for approval, with 2 visits approved, resulting in patient's visit schedule being interrupted every 2 weeks for just 2 visits on a suggested 12 visit/6 week program.

As an practitioner who is passionate about helping others improve their well-being, and priding myself on offering the best evidence-based practice for patients who entrust me with their care, it brings great distress that I am unable to provide the care that I believe is in the patient's best interest, limited instead by a system that optimizes the profit over the patient. It breaks my heart each time I have to share with the patient that their plan of care has been interrupted by prior authorization, even after appeals, especially when these individuals anticipate that their insurance premiums will pay out in coverage for these medically necessary interventions.

Thank you for your review of and support of AB972. I heartily believe it is in the best interest of the constituents of this beautiful corner of Northwest Wisconsin.

J M Stotz, PT, DPT WI License 12933-24

Jessica M Stotz, PT, DPT
Board-certified Clinical Specialist in Orthopaedic Physical Therapy

To whom it may concern:

My name is Caroline Klinker, and I am a pediatric physical therapist who practices in the Milwaukee area. I am writing to lend my support to Assembly Bill 972. Standards for appropriate utilization review and management must change in order for patients to get access to the care that they need.

As a single example, I provide care to a young child who is receiving post-operative care after a complex surgery to correct her congenital talipes equinovarus (clubfoot). My patient underwent a complex orthopedic surgery, followed by six weeks of immobilization. At her initial evaluation, she was unable to bear weight through her leg, had almost no active movement of her ankle or knee, presented with severe muscle atrophy throughout her affected leg, and was suffering from a post-operative condition called allodynia, in which she perceived any light touch to her foot as intense pain. She had to be carried from the waiting room into the physical therapy gym. After performing her evaluation, I made my medical recommendation for physical therapy twice a week for 6-8 weeks, followed by weekly physical therapy sessions for 6-8 weeks after that. Depending on her course, she could potentially require physical therapy at a decreased frequency after that. Her orthopedic surgeon agreed with this plan, which would require an absolute minimum of 18 visits. Her insurance granted five.

Five visits, at which point I would need to demonstrate some type of functional improvement, and request additional visits. For this particular patient, that means that every 2.5 weeks, I have to perform a comprehensive re-assessment, write up her progress, submit my request to her insurance company, and wait for approval. That means that every 2.5 weeks, her family is holding their breath, hoping that additional visits will be approved and that their child will get the care that she needs in order to be able to walk, run, jump, and play again. That means that every 2.5 weeks, I have to watch my inbox so that as soon as the approval comes in, I can schedule her appointments, hoping that there are openings left and that they don't cause her to miss hours of school each week.

I wish I could say that this child is the only patient I serve who experiences this unacceptable failure of our healthcare system, but she is not. 13% of my patients are at risk of experiencing delays, gaps, or refusals of care due to unreasonable prior authorization standards. These children are recovering from significant health challenges, including strokes, cancer, and complex surgeries, and the impact to their time-sensitive care caused by current utilization review and management practices puts their functional status at risk, potentially for the rest of their lives. And to make matters worse, they are not the only ones who suffer; the effects of this administrative burden trickle down even to children who have other types of insurance. My patients who have T19 Medicaid, for example, have seen delays in the submission of their prior authorization requests as our financial clearance team struggles to keep up with the ever-increasing pile of prior authorization requests for private insurances.

As physical therapists, we dedicate our lives to helping our patients live full, active, and independent lives. Right now, we need your help to do that. For the sake of the people of Wisconsin, please do your part to help patients get the care that they need by sponsoring Assembly Bill 972.

Sincerely,

Caroline A. Klinker, PT, DPT

Caroline Klinker, PT, DPT

Physical Therapy & Rehab Specialists

Clear Lake • Turtle Lake • Amery

Memorandum

Date: February 14, 2022
To: Interested parties
From: Becky Melton, Administrator and Emily Monson, PT, Practice Owner

Re: Standards for Appropriate Utilization Review/Management and Support of Assembly Bill 972

To whom it may concern:
We are a private practice physical therapy clinic in northwestern Wisconsin with 3 locations. Over the last few years, we have been dealing with increasing authorization components with insurance companies. We've seen an increase in 3rd party administrators that are implementing stricter guidelines and criteria for authorization approval which is affecting our practice on many levels.

AIM is one of the most stringent 3rd party administrators that we see the biggest limitations and complications with authorization. As billing administrator's, we see very limited amounts of visits being authorized along with poor cross over to Wisconsin Anthem BCBS Medicaid. We spend many hours on the phone troubleshooting denials for authorizations not being on file and learning that the systems are not working well with one another. One company blaming the other company, no one wants to take ownership of the issue, all the while, reimbursement is held up and more follow up is required by the billing team. As clinician's, we change how we document just for AIM. We look at how we write progress notes and goals to reflect exactly what they need to maximize visit potential ending with a clinical review and receive 2 visits. There is extra time being spent documenting, changing HOW we document, lengths of time on the phone only to receive minimal visits and then do it all over again. This takes us away from patient care which affects our revenue on a different level as we are not reimbursed for all the extra time spent. If we aren't treating patients, we aren't making money.

We experience this with other 3rd party administrators as well, Optum, Evicore and Cohere. There is no consistency with the algorithm of how the visits are calculated. We recently had an Optum authorization (UHC ins.) patient that was given 12 visits for her right shoulder pain back in November and now we are seeing the patient for the other shoulder, new injury, and were given 4 visits. This makes no sense? Evicore just authorized 4 visits for a high fall risk patient that needs conditioning but gave a non-surgical knee pain patient 12 visits?

Most **importantly,** how does all this effect the PATIENT experience? It leads to delays and continuity of care. It affects the healing process and creates frustration. This frustration leads to poor outcomes, mentally and physically. The patient loses confidence in the process, the insurance company and most of all physical therapy as a whole. Something needs to change and we support Assembly Bill 972.

Sincerely,

Becky Melton, Administrator

Emily Monson, PT and Practice Owner

417 Third Avenue • Clear Lake, WI 54005
p. 715-263-4103 • f. 715-263-4110

100 Becker Street • Turtle Lake, WI 54889
p. 715-986-4103 • f. 715-986-4128

930 Elden Avenue, Amery, WI 54001
p. 715-268-5103 • f. 715-268-5101

www.clearlakept.net

As a practicing Occupational Therapist with over 30 years experience I have seen an increasing trend of insurance companies such as Anthem, Aim, UHC OPTUM , Security Health Plan-Evicore and UR/UM Entity causing delays or denials that are impacting much needed care. There are numerous patient examples that can be described.

A specific example is of a recent patient that had rotator cuff surgery and was 10 weeks from surgery, unfortunately developed adhesive capsulitis of her shoulder. She required additional visits and her care was denied "due to lack of documentation regarding passive range of motion measurement gains not being indicative of functional improvement" after just 6 visits from the last progress report insurance requested a progress report with the addition of the patients functional improvements. The patient had to be placed on hold until this this was documented to meet the insurance demands. It should be noted that Passive Range of Motion gains are essential to prepare for Active range of motion that allows the functional progress. Hence, this delay caused patient to have to cancel much needed appointments and slowed her progress.

Overall, Insurance companies are contributing to the cost of managing health care, by demanding more frequent progress reports from therapists, demanding time-consuming peer-to-peer reviews and most importantly causing delays in patient care that can impair ultimate patient outcomes and costly additional surgeries.

Respectfully submitted,

Vivienne Neerdaels, OTR,CHT,CLT,COMT

February 13, 2022

I would like to share how the pre-authorization process has negatively affected my patients. The area of most profound impact has been with the acute hand trauma population. With winter weather, it is not uncommon to have snowblower injuries. These injuries often occur quickly, often involving the patient's dominant hand and require immediate hand surgery with a significant amount of therapy.

It has been very challenging to have patients who often have multiple fractures, tendon repairs and significant wounds that can require on average therapy at minimum two times per weeks for 14-16 weeks be granted a mere 6 visits for their initial authorization request. This requires the therapist to perform more frequent reassessments (taking away from valuable treatment time) and is often met with a delayed response following submission of requests for more therapy visits. This has been frustrating from a provider standpoint, as it is stressful for the patient to come into therapy not knowing if his or her insurance will be granting more visits. If the patient elects to cancel, this can be detrimental to the patient's outcomes, impairing the patient's function and sometime requiring further surgical intervention which increases the cost of care. Sometimes we don't get a response from the request for more visits for up to 14 days. This is ridiculous when a patient needs consistent care and can't wait up to 2 weeks before coming in for the next therapy session.

These situations have become all too common place and it has placed more burden on the provider to submit the required paperwork, sometimes as such short intervals as 2 or 3 visits. With peer-to-peer consults which occur after several authorization requests, it is extremely frustrating to spend up to 45 minutes on the phone with an insurance carrier only to receive an additional 2 visits, if the person from the insurance company authorizes more visits.

With these types of traumatic injuries, surgery is extremely expensive and the patient outcomes greatly depend on the patient's access to timely, consistent therapy. The pre-authorization process has put road blocks both for the patients and the providers, resulting in suboptimal results.

There needs to be a change in this process.

Ann Porretto Loehrke

Ann Porretto-Loehrke, PT, CHT
Physical Therapist
Certified Hand Therapist

RE: AB972

To whom it may concern,

Wisconsin residents with rehabilitative needs deserve prompt access to care and the ability to complete medically necessary treatments without delays or deterrence.

I have been a physical therapist for the past 30 years. In my current role as an Administrator of Outpatient Services for Greenfield Rehabilitation, I am afforded the ability to treat patients while also having a first- hand account of the administrative burden brought on by Utilization Review and Management (UR/UM) organizations.

As a treating therapist, I frequently have patients self-limit their care or refuse needed therapy services altogether because of the cost of their co-pay. I see physical therapists themselves limiting care for their patients to simply avoid the excessive documentation time required to complete re-authorization processes only to be micromanaged an additional 1-3 visits. I have been required to discharge patients, with documented progress of decreased pain, increased mobility, improved safety, and independence in function because their insurance company denied medically necessary and skilled therapy, because of denial of services only to have the same insurance company tell the patient their insurance company doe NOT limit the number of therapy visits in a year.

As an administrator, I am feeling the economic burden of adding clerical staff to support the constantly increasing burden UR/UM organizations demand. Increasingly, not only does my organization have a primary auth to obtain, a secondary auth to obtain, but in 2021 we also had patients with tertiary authorization requirements. It is becoming increasingly more difficult to staff these positions and keep up with timely authorizations/re-authorizations. This challenge delays and deters medically necessary care.

As a profession, Physical therapists are suffering. The burn-out rate is staggering. We are being crushed by UR/UM organizations by their excessive documentation demands. We feel acutely the inability to effectively carry out a plan of care to its conclusion to positively affect our patient's quality of life. Physical therapists must be able to utilize their medical expertise to evaluate patients and determine their needs and deliver services without wasting time and money on UR/UM and other administrative burdens rather than patient care.

Sincerely,

Nancy Johll Pearson, PT
Administrator, Outpatient Services and Senior Living
Greenfield Rehabilitation Agency
3360 Gateway Rd. Suite 100 Brookfield, WI 53045

Cell: 920-203-7095
Email: njohllpearson@grawi.com
Website: www.grawi.com

My name is Rebecca Van Heuklon. I am a physical therapist at a private practice clinic, Physical Achievement Center, in Oshkosh, WI. I have encountered significant issues with the prior authorization process that insurance companies have adopted, which has negatively affected the patients I am seeing. Patient's access to physical therapy care is being restricted with the current processes. Here are a number of issues I am encountering with my patients:

1. Patients are being approved for as little as 3 visits with the initial authorization, the first visit counting as the initial evaluation. I then have a second visit with the patient before the 3rd visit, which has to be a reassessment in order to show that the patient needs additional care. That effectively gives me 1 full visit (visit #2) to work with a patient before needing to go through the authorization process again. That is not enough time to make substantial progress and is a waste of time and resources to go through an entire reassessment again that quickly.

2. Authorized visits are not patient/situationally specific. I have patients who have significant and numerous comorbidities that affect how many visits they need to be seen for in order to achieve their pain and mobility goals. These comorbidities do not seem to be taken into account when the decision is made of how many visits are authorized. These patients need more visits than patients who are in better health and are being denied the opportunity to get to their highest level of function.

3. Patients are not being approved for additional visits when they ARE medically necessary. I recently had a patient who lived alone and was unsteady/unsafe moving around her home. She had been seen for 10 visits and then had a fall in her home. She was only approved for 11 visits. When I had requested approval for additional visits on the 11th visit due to the patient not being safe to move around her home, additional visits were denied. This puts the patient at substantial risk for falls in her home and further injury/need for medical intervention and limits her ability to remain in her home. That is not in the patient's best interest.

4. In our clinic's experience, the peer to peer review process is not for us to discuss why additional visits are medically necessary for a patient, but for the reviewer to explain to us why they are denying additional visits. The reviewer is not interested in hearing why we feel the patient needs more visits authorized. Their decision has already been made.

5. The restricted visits is leading to high price/low value imagery, persistent/unnecessary OTC and prescription medication, unnecessary high cost/low value pain interventions, and increased health care utilization, where the management of their impairments with physical therapy intervention would likely return the patient to their prior level of function at a lower cost and with very little side effects compared to medical management. I have a patient with low back pain who was instructed by her orthopedic doctor does not recommend she have surgery at this time and should continue physical therapy, as she has been making improvements. After that visit with her doctor, approval of additional visits were denied and the patient will now need to return to her doctor for additional pain management options, like medication and injections, and is considering moving forward with surgery. This would not have happened had the patient been able to continue physical therapy.

These situations are not the direction we as physical therapists would like to see our patients move in and does not help patients manage their pain and maximize their independence and function. Change needs to happen to provide better care to our patients. I support the Assembly Bill 972 to help provide our patients with the care they need and deserve.

Thank you,

Rebecca Van Heuklon DPT

Rebecca Van Heuklon, DPT, FAFS, FMR

Feb 11, 2022

Madison Office:
Room 220 South
State Capitol
PO Box 7882
Madison, WI 53707

Senator Chris Kapenga,

As your constituent, and a member of the American Speech Language Hearing Association, I am urging your support of a bill draft to amend 632.85 and 632.85 (3); and to create 632.85 (1) of the statues; related to: prior authorization for coverage for physical therapy as well as all other therapy services under health plans.

The bill is designed to address the burdens placed on health care workers, heath care employers, and patients affected by aggressive prior authorizations by commercial insurers for physical therapy services.

I am a Speech Language Pathologist who has worked in inpatient and outpatient therapy clinics and hospitals over my 30+ year career and currently within ProHealth Care. I actively treat patients on a weekly basis. I am also in an administrative leadership role overseeing quality for our Outpatient services, which includes all of Physical Therapy services, Occupational Therapy and Speech Language Pathology, covering most of the Oconomowoc area.. My positions have given me unique insights on the burden restrictive commercial insurer pre-authorization requirements place on patients, PT/OT/SLP therapists, and the health system and each year it becomes harder and harder to actually treat a pts medical condition in a timely manner.

From a quality perspective, timely access to appropriate healthcare services has the potential to improve quality and decrease overall health care costs. Pre-authorization leads to delays in patient care for common musculoskeletal conditions and neurological conditions that appropriate and effectively treated by conservative interventions therapy offers. I have first-hand experience of patient's waiting to receive care due to delays in care pre-authorization creates and of course we then bear the brunt of the patients frustration.

From a business, administrative and clinician standpoint, the pre-authorization process creates a significant burden on patient, practicing clinician, and health system. Commercial insurer pre-authorization requirements and forms vary from insurer to insure and often require redundant information in specified formats from both patients and clinicians. Much of this information is already captured in standard clinical process and shared with by clinicians with insurers in standard clinical documenting formats. These requirements effectively double the amount of paper work and administrative burden on clinicians and healthcare support services to meet the commercial insurer's pre-authorization requirements. Further, periods for pre-authorization approvals are often narrow; it could be 3-5 days later that we have to prove our value again. Often therapists have limited time to complete, turn-in, and receive authorization from the commercial insurer before the patient is able to be seen and receive insure benefits. If a clinician fails to meet pre-authorization requirements or the process, falls outside the time requirement insurers will deny coverage. This leads to significant re-work by the clinician and healthcare support services to re-apply for authorization, again leading to greater burden or delay. Ultimately, the burden affects the patient who is waiting for authorization to start physical therapy services and/or takes the risk and burden of being denied insurer coverage.

Ultimately, aggressive pre-authorization requirements pass administrative burden onto clinicians, health care employers, and the patient. Passing legislation limiting these burdensome practices has the potential to decrease overall health care costs, the burden on patients, healthcare system/employers, and patients not to mention increase the quality of care.

Thank you for your consideration,

Kathleen Levenhagen MS/CCC SLP

Supervisor of Contracted Therapy

ProHealth Care

Kathleen.levenhagen@phci.org

Feb 11, 2022

Madison Office:
Room 204 North
State Capitol
PO Box 8953
Madison, WI 53708

Representative Adam Neylon

As your constituent, and a member of the American Speech Language Hearing Association, I am urging your support of a bill draft to amend 632.85 and 632.85 (3); and to create 632.85 (1) of the statues; related to: prior authorization for coverage for physical therapy as well as all other therapy services under health plans.

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I am a Speech Language Pathologist who has worked in inpatient and outpatient therapy clinics and hospitals over my 30+ year career and currently within ProHealth Care. I actively treat patients on a weekly basis. I am also in an administrative leadership role overseeing quality for our Outpatient services, which includes all of Physical Therapy services, Occupational Therapy and Speech Language Pathology, covering most of the Oconomowoc area.. My positions have given me unique insights on the burden restrictive commercial insurer pre-authorization requirements place on patients, PT/OT/SLP therapists, and the health system and each year it becomes harder and harder to actually treat a pts medical condition in a timely manner.

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Ultimately, aggressive pre-authorization requirements pass administrative burden onto clinicians, health care employers, and the patient. Passing legislation limiting these burdensome practices has the potential to decrease overall health care costs, the burden on patients, healthcare system/employers, and patients not to mention increase the quality of care.

Thank you for your consideration,

Kathleen Levenhagen MS/CCC SLP

Supervisor of Contracted Therapy

ProHealth Care

Kathleen.levenhagen@phci.org

Thank you for hearing our testimony today.

I am Heike Holzapfel from Waukesha, WI

As your constituent, and a member of the American Physical Therapy Association- Wisconsin, I am urging your support of a bill draft to amend 632.85 and 632.85 (3); and to create 632.85 (1) of the statues; related to: prior authorization for coverage for physical therapy and other services under health plans.

The bill is designed to address the burdens placed on health care workers, heath care employers, and patients affected by aggressive prior authorizations by commercial insurers for physical therapy services.

I am a physical therapist who has worked in outpatient physical therapy clinic at ProHealth Care in Hartland, WI for the last 2 years and 17 years prior to that in Sussex. I actively treat patients on a weekly basis. I am also in an administrative leadership role overseeing quality for our Orthopedics and Sports Medicine services, which includes all of physical therapy services, covering most of Waukesha County. Both positions have given me unique insights on the burden restrictive commercial insurer pre-authorization requirements place on patients, physical therapists, and the health system. Medically necessary, physical therapist services are delayed, ultimately impacting patients' clinical outcomes, due to the amount of time and resources Physical Therapists must spend on documentation and administrative tasks. The volume of these tasks also leads to dissatisfaction and burnout among staff and in the middle of a public health crisis, it is essential that we avoid staff shortages. It is imperative that policymakers and third-party payers advance policies that streamline documentation requirements, standardize prior authorization and payer coverage policies, and eliminate unnecessary regulations. Prior authorization requirements negatively impact patients' clinical outcomes resulting in further medical care and possible further reliance on medications. I personally know that when I see that a patient has certain insurances as their carrier, it makes me nervous knowing that likely they will never get the complete care they deserve because of the difficulties needed to get additional visits. When you do your due diligence and put in the time and effort to request additional visits and only get 1 or 2 approved and know that you need to repeat this whole process the following week, it is extremely frustrating and time consuming.

From a quality perspective, timely access to appropriate healthcare services has the potential to improve quality and decrease overall health care costs. Pre-authorization leads to delays in patient care for common musculoskeletal conditions appropriate and effectively treated by conservative interventions physical therapy offers. I have first-hand experience of patient's waiting to receive care due to delays in care pre-authorization creates.

From a business administrative and clinician standpoint, the pre-authorization process creates a significant burden on patient, practicing clinician, and health system. Commercial insurer pre-authorization requirements and forms vary from insurer to insure and often require redundant information in specified formats from both patients and clinicians. Much of this information is

already captured in standard clinical process and shared with by clinicians with insurers in standard clinical documenting formats. These requirements effectively double the amount of paper work and administrative burden on clinicians and healthcare support services to meet the commercial insurer's pre-authorization requirements. Further, periods for pre-authorization approvals are often narrow. Often physical therapists have limited time to complete, turn-in, and receive authorization from the commercial insurer before the patient is able to be seen and receive insure benefits. If a clinician fails to meet pre-authorization requirements or the process falls outside the time requirement insurers will deny coverage. This leads to significant re-work by the clinician and healthcare support services to re-apply for authorization, again leading to greater burden or delay. Ultimately, the burden affects the patient who is waiting for authorization to start physical therapy services and/or takes the risk and burden of being denied insurer coverage.

Ultimately, aggressive pre-authorization requirements pass administrative burden onto clinicians, health care employers, and the patient. Passing legislation limiting these burdensome practices has the potential to decrease overall health care costs, the burden on patients, healthcare system/employers, and patients not to mention increase the quality of care.

Thank you for your consideration,

Heike Holzapfel, PT

Madison State Capitol, Room 310 South February 11, 2022

PO Box 7882

Madison, WI 53707

Dear Honorable Senator Dale Kooyenga,

As your constituent, and a member of the American Physical Therapy Association- Wisconsin, I am urging your support of a bill draft to amend 632.85 and 632.85 (3); and to create 632.85 (1) of the statues; related to: prior authorization for coverage for physical therapy and other services under health plans.

The bill is designed to address the burdens placed on health care workers, heath care employers, and patients affected by aggressive prior authorizations by commercial insurers for physical therapy services.

I am a physical therapist who had worked in an outpatient physical therapy clinic for ProHealth Care in Waukesha, WI for 18 years, with over 28 years of experience as a physical therapist. I am now in an operational management role with ProHealth Care overseeing quality and access for our Orthopedics and Sports Medicine services, which includes all of physical therapy services for fourteen outpatient clinics, covering most of Waukesha County and surrounding communities. Both positions have given me unique insights on the burden restrictive commercial insurer pre-authorization requirements place on patients, physical therapists, and the health system.

From a quality perspective, timely access to appropriate healthcare services has the potential to improve quality and decrease overall health care costs. Pre-authorization leads to delays in patient care for common musculoskeletal conditions appropriate and effectively treated by conservative interventions physical therapy offers. I have first-hand experience of patients' waiting to receive care due to delays in care pre-authorization creates. Interruptions in care are frequent due to the required waiting period to receive authorization. My experience has shown this to be a detriment to patient care; patients lose momentum and continuity, care becomes extended and ultimately more costly, acute conditions turn into chronic conditions which lead to more treatments, tests, medications, and reduction in quality of life. Insurers expect reassessments to be done at unrealistic intervals in order to approve our ability to continue physical therapy services, often too frequent. The consequence of this is that it does not allow patients realistic recovery in the required intervals (sometimes as frequent as every two therapy visits), thereby "appearing" that therapy is not benefitting. These demands also have the added negativity of taking precious time away from valuable and meaningful treatment interventions for patients by requiring therapists to assess patients at unrealistic intervals. Insurers are ultimately dictating how we can provide care, and wasting all of our tax payer dollars on unnecessary reassessments, highly dissatisfying to all when we all know health care costs can be prohibitively expensive. We are the puppets and they are the puppet masters; our audience, the patients, ultimately suffer physically and financially. Unsurprisingly, the insurers break records

in annual revenue. This is a system so far out of balance, and the patients' best interests are not the primary focus in current state.

From a business administrative and clinician standpoint, the pre-authorization process creates a significant burden on patient, practicing clinician, and health system. Commercial insurer pre-authorization requirements and forms vary from insurer to insure and often require redundant information in specified formats from both patients and clinicians. Much of this information is already captured in standard clinical process and shared with by clinicians with insurers in standard clinical documenting formats. These requirements effectively double the amount of paper work and administrative burden on clinicians and healthcare support services to meet the commercial insurer's pre-authorization requirements. Further, periods for pre-authorization approvals are often narrow. Often physical therapists have limited time to complete, turn-in, and receive authorization from the commercial insurer before the patient is able to be seen and receive insure benefits. If a clinician fails to meet pre-authorization requirements or the process falls outside the time requirement insurers will deny coverage. This leads to significant re-work by the clinician and healthcare support services to re-apply for authorization, again leading to greater burden or delay. As someone who works in an administrative leadership role, I have the ability to see how many hands have to touch our claims to get them "just right" so we are reimbursed for our care. This so often includes many departments within a healthcare system; billing, coding, revenue cycle, compliance, just to name a few. All of these parties needing involvement due to the burden of therapy authorizations has become untenable. What this leads to is higher health care costs for the patients. This is a direct relationship to the administrative burden laid upon us by the insurers. In truth today, the ability to provide care from start to finish requires the skills and expertise of so many individuals just to get a bill out the door because of jumping through hoops to meet insurers' requirements. Ultimately, the burden always most intimately affects the patient who is waiting for authorization to start physical therapy services and/or takes the risk and burden of being denied insurer coverage. The most significant consequence is that patients opt out of necessary care completely, which is unacceptable.

Ultimately, aggressive pre-authorization requirements pass administrative burden onto clinicians, health care employers, and the patient. Passing legislation limiting these burdensome practices has the potential to decrease overall health care costs, the burden on patients, healthcare system/employers, and patients not to mention increase the quality of care.

Thank you kindly for your consideration,

Christina Dyess, PT

Manager of Outpatient Therapy Services at ProHealth Care, Inc.

Email; Christina.dyess@phci.org

Phone: 262-928-6285

MARQUETTE UNIVERSITY

BE THE DIFFERENCE.

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February 10, 2022

Assembly Health Committee
Wisconsin State Capital
2 East Main Street
Madison, WI

RE: Assembly Bill 972

To Whom It May Concern:

My name is Dr. Jeffrey Wilkens, PT, DPT, OCS. I am a physical therapist licensed in the state of Wisconsin. I am the Clinic Director of the Marquette University Physical Therapy Clinic and Neuro Recovery Clinic as well as an Assistant Clinical Professor. I practice and manage clinics at Marquette University in the city of Milwaukee. I am writing in support of Assembly Bill 972. Our state professional association, APTA Wisconsin, has been diligently and thoughtfully working to help providers and patients break down the barriers to improve access to the care provided by physical therapists. One of the largest such barriers in recent years has been the utilization review or management and prior authorization processes that are employed by 3rd party payers in an effort to reduce claims expenditures and utilization of our services that are most often much needed by the patient.

Over the past several years, we have experienced much more frequent denials, delays, and determents of medically necessary care for our patients. In many of these cases, the patients have calendar year limits of at least 20 visits per year and sometimes as high as 90 visits, whose care is unnecessarily delayed or halted by an extremely arduous and arbitrary utilization review process. In most of these cases, visits are limited to less than 10 visits for a given diagnosis many of which are complex rehabilitations following orthopedic surgeries, complex spinal conditions, and other such debilitation conditions. In the case of orthopedic surgeries which often cost tens of thousands of dollars, it is extremely short sighted to defer or delay the subsequent rehabilitation which ensures that the surgery is successful. In other cases, patients are offered or choose physical therapy as a conservative treatment option to avoid surgeries as well as being prescribed highly addictive opioid medications. We have an opioid epidemic in this state and physical therapy is one of the primary alternative treatment options for painful conditions. Again, the tactics of micromanagement and substantial administrative burden put the access of conservative and effective care for the patient at risk.

Most authorization requests are submitted via provider portal and the 3rd party payor or utilization review company do not actually review documentation of evaluation or progress notes. Our therapists spend an hour with each patient upon evaluation, gathering health history and previous interventions

tried, performing tests and measures, determining and documenting for medical necessity and establishing goals, yet none of these are reviewed in online submission. Simply asking questions like "Was the evaluation low, moderate or high complexity?" "What outcome measures were gathered?" "Was surgery performed in the last three months?" doesn't give a full picture of the history of the patient and the thorough and customized goals and treatment plan prescribed for the patient. Most often, our treatment plans aren't even achievable because the patient's visit limits are cut short by this authorization process. Most recently, our billing specialist submitted a prior authorization request to AIM for a patient who was referred by her ortho doctor for an acute back pain flare-up. This patient has a "30 visit limit for physical therapy" but requires prior authorization through AIM. A thorough examination, special testing and outcome measures were gathered and short- and long-term goals were established with a recommendation of 2 visits per week for 6-8 weeks. We submitted to AIM via their portal (which does not allow us to include or attach the actual evaluation or referral) and we were granted 5 visits--- meaning that, in two weeks, our billing specialist will again have to submit another authorization for medically necessary care.

As a physical therapist, we are duty-bound to provide medically necessary care for our patients and as such cease care when not medically necessary. I would suggest that insurance companies be required to allow a minimum number of visits before the utilization review process starts. In the example of patient who starts rehab after a total knee replacement that has 30 visits per calendar year. If that patient needs prior authorization and that review process then only allows 2 visits, our staff then must spend time and complete arduous administrative tasks in order to get more visits. When that next review again only allows 2 visits, this process may have to take place 5-10 times for a condition that likely will require 10-15 visits of physical therapy care over the course 3-4 months for optimal outcome. In many cases, after multiple prior authorization submissions where we are granted 2-4 visits each, we then are required to speak with a medical reviewer. These conversations are time-consuming and frustrating for our therapists as we are often told that the patient is "back to pre-injury status" when that is not the case, and the documentation shows and supports that. As you can see, this process is costly as well as potentially a deterrent to care delivery.

In summary, I urgently request that you support Assembly Bill 972 to improve the ease of access to the needed, affordable, and effective care provided by physical therapists to the citizens of Wisconsin.

Sincerely,

Dr. Jeffrey Wilkens, PT, DPT, OCS
Clinic Director
Assistant Clinical Professor
WI license #6312-24
Jeffrey.wilkens@marquette.edu
414-288-6287

February 10, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I am writing to encourage your support of **Assembly Bill 972**. Its contents significantly impact the day to day operations at our clinics. Colleagues that are doctoral-level trained are taking repeated clinical measurements and composing extensive documentation, in attempts to get physical therapy visits authorized. Then it is not uncommon for the AIM or EVICORE systems to take 1-3 weeks to respond. If unapproved, it is not uncommon for clinicians to attempt peer-to-peer or medical review phone calls with the insurance company that may involve canceling other patients' scheduled appointments to accommodate the time required. In addition, disruption in therapy care plans are challenging from a scheduling standpoint, and they often result in prolonged and/or poorer functional outcomes.

We have an authorization team that exclusively is assigned the task of obtaining approval of therapy visits. They are frustrated by the insurance companies delayed responses and how frequently they claim that they did not receive information sent.

Patients that have insurance managed by AIM or EVICORE are very frustrated. Their physical therapy care is being dictated by someone separate from their medical team, despite having a policy that relays that they have outpatient therapy benefits. This is deceiving and unfair.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Kelsey Smith, PT, DPT
Physical Therapist, Prevea/HSHS
Eau Claire, WI

Amy Reiter

From: Anason, Jacob D <Jacob.Anason@hshs.org>
Sent: Thursday, February 10, 2022 9:43 AM
To: Rep.Sanfelippo@legis.wisconsin.gov
Cc: aptawi@aptawi.org
Subject: Support of Assembly Bill 972

February 10, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

Please closely review **Assembly Bill 972.** I am a Wisconsin physical therapist that is pleading for you to act. There are so many patients that are experiencing suboptimal physical therapy outcomes due to a system drip feeding them their healthcare benefits.

While I am frustrated by all the highlights denoted in the bill, I am most disturbed by the random assignment of authorized visits for my patients that are post-surgical. Their surgical procedure is authorized to the tune of thousands (maybe tens of thousands) of dollars, but they will nitpick the allowance of (maybe) $100 reimbursement per physical therapy visit? It makes no logical sense, especially if completion of physical therapy ensures that the patient can function how they expected post-operatively.

I have a current patient that is an electrician. He recently had a massive rotator cuff repair. AIM only authorized 9 visits round one. Then, 4 visits during my round two of authorization with them. Other patients with this diagnosis undergo 25-35 visits of physical therapy. He will need the upper end of the spectrum, because of his occupation. AIM's choice to ration out his visits will negatively affect his outcomes.

This is a sad way to treat people and an awful process to be part of. The procedure of getting physical therapy visits authorized has literally become a game. There are so many hoops to jump that it is inevitable that someone gives up.

Let us do our job. Let the patients receive the medical benefits they have paid premiums for. Stop micromanaging a profession that is instrumental in the conservative, cost-effective management of musculoskeletal issues.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Jacob Anason, PT, DPT
Physical Therapist, Prevea/HSHS
Green Bay, WI

Amy Reiter

From: Jodko, Wojtek <WojtekJodko@hshs.org>
Sent: Thursday, February 10, 2022 2:20 PM
To: aptawi@aptawi.org
Subject: Assembly Bill 972

February 9, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I encourage your support of **Assembly Bill 972.**
I have a patient that is struggling with obtaining authorized physical therapy visits from EVICORE. She had a knee replacement with fair outcomes obtained before she was out for six weeks with pneumonia. Upon her return to physical therapy, I sent EVICORE extensive documentation in a re-evaluation document. They approved only six visits. This patient is making progress, but it is slow. She also has dialysis three days per week, which coincided (same day) with her therapy visit yesterday—the day I needed to quantify her improvement to EVICORE for more visits. Because it was a bad day, this patient's functional test scores did not show improvement. I will write out a long narrative, but based on my experience, it is doubtful this lady (who desperately needs therapy) will get any additional visits authorized. Their computer software is not a medical professional with clinical reasoning capabilities.
I am very tired and frustrated by EVICORE'S game of authorization. I want to use my energy to help my patients get better, not plead to their insurance every other week that they are. This is a poor system that needs reform. My EVICORE patients deserve better.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Thank you,

Wojciech Narkiewicz-Jodko, MPT, COMT, CMTPT
Physical Therapist, Prevea/HSHS
Green Bay, WI

Wojtek Narkiewicz-Jodko, MPT,COMT,CMTPT
Physical Therapist, Cert.Orthopedic Manual Therapist,Cert.Myofascial Trigger PointTherapist

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Wojtek.Jodko@hshs.org

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Amy Reiter

From: Ruess, Kelly <Kelly.Ruess@hshs.org>
Sent: Thursday, February 10, 2022 11:29 AM
To: Rep.Sanfelippo@legis.wisconsin.gov; aptawi@aptawi.org
Subject: Assembly Bill 972

February 10, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I am writing to encourage your support of Assembly Bill 972. Its contents significantly impact my day-to-day operations as a physical therapist. Myself and my colleagues that are doctoral-level trained are required to spend considerable clinic time taking repeated clinical measurements and composing extensive documentation, in attempts to get physical therapy visits authorized. This often takes away from needed treatment time in which the patients are seeking and paying for each visit.
It is not uncommon for the AIM or EVICORE systems to take 1-3 weeks to respond to requests for further authorization. If unapproved, it is not uncommon for colleagues to attempt peer-to-peer or medical review phone calls with the insurance company that may involve canceling other patients' scheduled appointments to accommodate the time required. In addition, the disruption in therapy plan of care is challenging from a scheduling standpoint, and often result in the patient having prolonged therapy care and/or poorer functional outcomes.
Patients that have insurance managed by AIM or EVICORE are very frustrated. Their physical therapy care is being dictated by someone separate from their medical team, despite having a policy that relays that they have outpatient therapy benefits. The patients feel that they have been deceived after experiencing medical care that is dictated by AIM or EVICORE.
Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Kelly Ruess, PT, DPT
Physical Therapist, Prevea/HSHS
Outpatient Therapy Facilitator
Green Bay, WI

Kelly Ruess, PT, DPT
Physical Therapist
Prevea Therapy Institute
Clinical Facilitator – East Mason and Luxemburg Clinics
Clinic phone: (920) 272-3380 ext: 75079
Cell phone: (906) 282-6727

Amy Reiter

From: Cooley, Dirc R <dirc.cooley@prevea.com>
Sent: Thursday, February 10, 2022 9:37 AM
To: aptawi@aptawi.org; Rep.Sanfelippo@legis.wisconsin.gov
Subject: Support Assembly Bill 972

February 9, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I strongly encourage you to support **Assembly Bill 972**. As a physical therapist, it is a daily frustration to watch my patients micromanaged by an outside source that seems uneducated about what medically necessary care includes. Here is a prime example of AIM's incompetence. I submitted for authorized visits for my 45-year old patient with hip pain. I received approval for 4 visits. When I provided documentation and requested additional visits, I waited 10 days for a response, then was denied.

I had the opportunity to do a peer-to-peer phone consult. On the call, the consulted entered information I provided. The AIM consultant then stated, "The computer did not see a follow-up FOTO score nor that long-term goals were met, so that was a significant part of the denial." I discussed that long-term goals are expected to be at time of discharge. My patient is not ready for discharge, or I would not have requested additional visits. I continue to report progressions from the progress note I had submitted while the consultant manually entered them. The progress report I had submitted clearly was never read. I am then transferred to an MD for final review. The MD asks me to verify that I am a licensed physical therapist. Then he says, "The computer calculates 4 more visits."

At this point, the patient had been on hold from PT for 17 days. These 4 additional visits needed to be used before the AIM-approved end date two weeks later. We worked hard to get her back on my schedule, but ran out of time. AIM would not extend the end date of the authorization period to allow her to be seen for the last authorized visit of that set. When I sent for round three of authorization, I was issued 2 visits. My final authorization request for this patient was submitted and denied by AIM 7 days later.

With all the delays in plan of care, this patient never makes significant progress towards goals. The entire rehab process has been stretched to 15 weeks and the patient is now going for hip MRI and considering surgical intervention. This case has been clearly mismanaged by AIM through unnecessary delays in the plan of care while awaiting their auth process. When AIM does authorize visits, they are back dating to when the authorization was initially requested. This can cost 1-2 weeks of patient care time. AIM denies requests to extend the auth dates. This hampers the therapist's ability to adjust frequency and duration for best practice to manage their respective clients. We are being forced to get appointments in by the end of the auth date, in some cases a frequency which is not needed. This not an efficient nor cost-effective way to manage physical therapy plans of care.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Sincerely,

Dirc Cooley PT, DPT
Clinic Facilitator, Prevea Therapy Institute
Ashwaubenon and Howard
Dirc.cooley@prevea.com
Office: (920) 496-4710 X 74844
Cell: (920) 530-2594
Fax: (920) 429-1708

Amy Reiter

From: Verbeten, Ashley A <Ashley.Verbeten@hshs.org>
Sent: Thursday, February 10, 2022 9:16 AM
To: Rep.Sanfelippo@legis.wisconsin.gov
Cc: aptawi@aptawi.org
Subject: Support of Assembly Bill 972

TO: Chairman Sanfelippo and Members of the Assembly Health Committee
RE: Support of Assembly Bill 972

February 8, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

It is with great frustration that I reach out to you to support **Assembly Bill 972.** I am a physical therapist that has seen the firsthand concerns of restricted and delayed insurance authorization for my patients.
A recent example includes Brittney, a 32-year old who had just had left shoulder surgery the month prior. She uses a sling/pillow for immobilization. She understands that this will be a long rehabilitation process, but she is highly motivated. Brittney has increased risk of frozen shoulder, because she is diabetic. Therefore, it is crucial for us to get her shoulder safely moving within the healing constraints of a fresh repair to ensure optimal outcomes. Her long-term goals include returning to caregiving individuals with behavior problems, which can be physically demanding.
I jumped through all appropriate hoops and AIM initially authorized 6 physical therapy visits. As you know, post-operatively, these visits are used quickly. Therefore, I have to spend part of her treatment time 3 weeks later to take additional measurements for AIM that may or may not show progress toward her long-term goals, as she has just been cleared to actively move the weight her own arm. AIM approved 3 more visits, which means next week I'll need to repeat this ridiculous process.
Brittney does not deserve this. She did not expect barriers to completing the necessary rehabilitation to make her surgical outcome successful. She also should not have to sacrifice valuable physical therapy treatment time to repeatedly appease her insurance company to ensure ongoing visit authorization.
Luckily, Brittney has not experienced delays in treatment.... yet. Other patients I've had went a few weeks between authorization of their next 2-3 visits. It is not uncommon that this process results in patient regression, frustration, and eventual defeat. I feel that patients with AIM definitely have an unfair disadvantage to consistent outpatient physical therapy care.
Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Ashley Verbeten, PT, DPT
Physical Therapist, Prevea/HSHS
Outpatient Therapy Manager
Green Bay, WI

Amy Reiter

From: Newhouse, Sam L <Sam.Newhouse@hshs.org>
Sent: Thursday, February 10, 2022 8:26 AM
To: Rep.Sanfelippo@legis.wisconsin.gov
Cc: aptawi@aptawi.org
Subject: Support of Assembly Bill 972

February 10, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I feel compelled to reach out to you to support **Assembly Bill 972.** I witness patient dissatisfaction and frustration with the authorization process routinely, as well as less than ideal outcomes due to delayed responses and piecemeal approvals.

This example quickly comes to mind. "Pete" is a 60-year-old who underwent a total shoulder arthroplasty. He is self-employed construction worker, who is anxious to return to work. Other patients with this diagnosis undergo 25-35 visits of physical therapy. He will need the upper end of the spectrum, because of his occupation. I have educated him that the rehabilitation process to resume his overhead occupational tasks will take, on average, 4-6 months.

Requesting insurance authorization for "Pete" was very frustrating with AIM. They initially approved 9 visits, then 4 visits, then 4 visits, then 6 visits. This incremental offering of minimal visits results in a lot of treatment time spent measuring and proving progress, often only with 1-2 weeks between reports to AIM. There seems to be no rhyme or reason to the number of visits authorized each time. In my option, it is a maddening game that makes no sense... at the expense of the patient.

Patients going through AIM's authorization process are hesitant to schedule appointments that are not approved. With busy clinician schedules, this often results in scheduling delays to resume care. On the contrary, the patients that are optimistic and book appointments out are often cancelling while they await AIM's verdict. This affects my productivity and is time consuming to attempt contacting other waitlist patients to fill this appointment time.

"Pete" and my other patients with AIM insurance authorization requirement deserve better. They deserve uninterrupted medically necessary service. They deserve optimal outcomes post-operatively to allow safe return to their occupations. They deserve to receive the care they interpret their hard-earned insurance premiums are paying for.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Sam Newhouse, PT, DPT

Physical Therapist, Prevea/HSHS
Green Bay, WI

Amy Reiter

From: Cooley, Karen K <Karen.Cooley@hshs.org>
Sent: Thursday, February 10, 2022 8:12 AM
To: Rep.Sanfelippo@legis.wisconsin.gov
Cc: aptawi@aptawi.org
Subject: Support of Assembly Bill 972

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I am writing to encourage your support of **Assembly Bill 972**. Its contents significantly impact the day to day operations at our clinics. Colleagues that are doctoral-level trained are taking repeated clinical measurements and composing extensive documentation, in attempts to get physical therapy visits authorized. Then it is not uncommon for the AIM or EVICORE systems to take 1-3 weeks to respond. If unapproved, it is not uncommon for clinicians to attempt peer-to-peer or medical review phone calls with the insurance company that may involve canceling other patients' scheduled appointments to accommodate the time required. In addition, disruption in therapy care plans are challenging from a scheduling standpoint, and they often result in prolonged and/or poorer functional outcomes.

We have an authorization team that exclusively is assigned the task of obtaining approval of therapy visits. They are frustrated by the insurance companies delayed responses and how frequently they claim that they did not receive information sent.

Patients that have insurance managed by AIM or EVICORE are very frustrated. Their physical therapy care is being dictated by someone separate from their medical team, despite having a policy that relays that they have outpatient therapy benefits. This is deceiving and unfair.

Please support Assembly Bill 972.
https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Karen

Karen Cooley, PT, DPT
Physical Therapist, Prevea/HSHS
Outpatient Therapy Manager
Green Bay, WI

February 10, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I am writing to encourage your support of Assembly Bill 972. The contents of the bill impact not only the daily work flow within the clinic and my ability as a clinician to provide quality care to those carrying this type of insurance, but also the patients' outcomes and ultimately their return to function.

I am currently dealing with a case in which a young female patient was seen to address knee pain at the end of last year. She had improved and was able to return to sport and daily activities without issue within the provided visits, however, has sustained a significant fracture to the same knee since the last episode of care. As she is again experiencing knee pain, albeit from a completely different diagnosis, she has been denied continued care after no more than 4 visits as AIM recognizes only that the patient has continued knee pain of the same knee. She is not currently able to return to sport and has yet to completely wean from her support brace. She is an extremely active individual. Her inability to participate in sporting activities not only affects her physical but also mental health, especially at such a young age.

I pride myself on staying on top of my patient's referrals and what their insurance will and won't allow and have never had to deal with the rate of denial that I have had to deal with when it comes to AIM/EVICORE. The impact that their lack of coverage has on patients' lives is immense! Allow us to treat patients as they should be treated and reduce their risk of further and/or future injury.

Please support Assembly Bill 972. https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Samantha Albrecht, PT, DPT
Physical Therapist, Prevea/HSHS
Menomonie, WI

Amy Reiter

From: Peterson, Ashley <Ashley.Peterson@hshs.org>
Sent: Thursday, February 10, 2022 1:53 PM
To: aptawi@aptawi.org
Subject: assembly bill 972

February 10, 2022

Dear Chairman Sanfelippo and Members of the Assembly Health Committee,

I am writing to encourage your support of Assembly Bill 972. Its contents significantly impact the day to day operations at our clinics. Colleagues that are doctoral-level trained are taking repeated clinical measurements and composing extensive documentation, in attempts to get physical therapy visits authorized. Then it is not uncommon for the AIM or EVICORE systems to take 1-3 weeks to respond. If unapproved, it is not uncommon for clinicians to attempt peer-to-peer or medical review phone calls with the insurance company that may involve canceling other patients' scheduled appointments to accommodate the time required. In addition, disruption in therapy care plans are challenging from a scheduling standpoint, and they often result in prolonged and/or poorer functional outcomes.

We have an authorization team that exclusively is assigned the task of obtaining approval of therapy visits. They are frustrated by the insurance companies' delayed responses and how frequently they claim that they did not receive information sent.

Patients that have insurance managed by AIM or EVICORE are very frustrated. Their physical therapy care is being dictated by someone separate from their medical team, despite having a policy that relays that they have outpatient therapy benefits. This is deceiving and unfair.

Please support Assembly Bill 972. https://docs.legis.wisconsin.gov/2021/proposals/reg/asm/bill/ab972#

Respectfully,

Ashley Peterson, PT, DPT

Physical Therapist, Prevea/HSHS

Green Bay, WI

Ashley M. Peterson, PT, DPT
Prevea Therapy Insititute
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1726 Shawano Ave.
Green Bay, WI 54303
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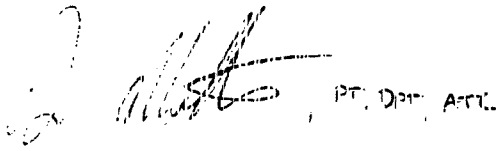
Ashley.Peterson@hshs.org

feel it best fit to allow a skilled physical therapist to treat these patients without the worry of limited visits or delay in treatment.

I thank you for hearing my concern regarding the prior authorization process utilized by many insurance companies as this greatly impacts the health and well-being of our citizens requiring timely and highly effective physical therapy services. I ask the committee to support AB 972 as this change is needed to foster improved care, without unnecessary delay, to our community and its constituents.

Sincerely,



Devin Mattson, PT, DPT, ATC

February 16, 2022

Honorable Members of the Wisconsin Assembly Committee on Health,

Good morning. I appreciate the opportunity to testify in support of Assembly Bill #972.

My name is Kip Schick, and I am a physical therapist, and I've worked for UW Health in Madison for almost 20 years. I've been active on payment and practice issues at the state and national levels for more than 15 years and currently serve on the Board of Directors for the American Physical Therapy Association. I'm also a Past President of APTA Wisconsin.

Throughout the majority of my career, the administrative burden from prior authorization that has been placed on physical therapists has increased steadily over the years. Frequently prior authorization requirements are applied broadly and are required simply on the initiation of physical therapist services even when occurring in-network…this results in a physical therapist needing to justify their plans of care to secure coverage by an insurance payer despite the patient having an established physical therapy benefit and seeing an in-network provider.

Are there times when prior authorization is indicated? Absolutely. However, prior authorization requests should not be required at the start of physical therapy for common musculoskeletal conditions such as low back pain, knee pain, and shoulder pain provided the physical therapist recommends that treatment is indicated. Similarly, prior authorizations should not be required to initiate post-operative care…specific examples include rehabilitating patients following joint replacement surgery or knee surgery. Instead, prior authorization requests are more appropriate to consider as the care of the patient evolves over time with specific attention placed on key metrics such as patient progress and resource utilization.

All too often, initial prior authorization requests by insurance payers are applied as a "one size fits all" approach that ask all providers to jump through the same hoops regardless of patient presentation and/or plans of care. And the result of all this extra work? Care is often delayed, provider administrative expense increases, and ultimately our experience is that additional visits almost always get approved.

I'd like to highlight a few things with each of these three outcomes. The first is delayed care…this is a regular outcome when prior authorizations are used regularly and broadly without specificity. Why is this important? Research shows that delays in care result in longer episodes of care, less favorable patient outcomes, and more expense. Patients and providers generally don't benefit in this scenario. Response times from insurance companies are not uniform, consistent, or known. This means follow-up appointments are frequently delayed or have to be rescheduled, which is obviously inconvenient for patients and also difficult to accommodate in a busy practice. We regularly experience delays of up to 2 weeks for prior authorizations that are required following an initial visit. This is not the right way to provide care for patients, especially those with acute conditions or changing symptoms.

Next- I'll provide my perspective on increased provider administrative expense with prior authorizations. This is undoubtedly an outcome…time and effort are required for our providers

and office staff to submit whatever information is requested…and of course, the payer has to review the information, make determinations, and communicate its decisions. The expenses from this effort ultimately get absorbed by patients, payers, employers purchasing benefits for their employees, and our physical therapy practices. To give this some perspective, in addition to our clinical providers, our health system has a team of individuals who work behind the scenes to assist with work related to managing the prior authorization process because if it's not well managed by the provider, payment decreases and our patients lose coverage. At UW Health this equates to more than five full-time staff dedicated to outpatient rehabilitation, and these individuals often have frequent overtime due to the workload.

And finally, in our experience, our effort in the prior authorization process generally results in an approval…perhaps for fewer visits…but generally to keep things going. And what happens when fewer visits are regularly approved? This means that in order to get more visits approved in the future, a physical therapist has to repeat tests and measures as part of a more formal reassessment to justify future prior authorization requests- this takes time away from on-going intervention to progress the patient. This pattern occurs regularly and routinely, which says a lot about the utility of the process, especially when applied broadly. So much effort, angst, and expense in which the time and effort of our patients, providers, and staff could have been directed elsewhere.

In the clinic, what is the implication? Our physical therapists spend increasing time away from direct patient care, which results in increased administrative burden that is time consuming, insufficiently transparent, and frustrating…all of this leads to decreased job satisfaction. And with our patients, their primary concerns are uncertainty in whether or not physical therapy care will be covered while often times having to delay care while waiting for a determination.

I appreciate the opportunity to testify in support of Assembly Bill #972, and I am happy to answer any questions. Thank you.

Regards,

Kip Schick

Kip Schick, PT, DPT, MBA
42 South Owen Drive
Madison, WI 53705

TO: Chairman Sanfelippo and Members of the Assembly Health Committee
FROM: Kate Lewis
DATE: February 16, 2022
RE: Support of Assembly Bill 972

I am here today, because I think physical therapists should be fairly compensated for the services they provide. I am here today, because my health insurance was marketed as allowing 50 physical therapy visits per family member per calendar year, but only 27 of my 50 covered visits have been paid for by my insurance company. I am here today, because if it weren't for physical therapists, I would be walking with a cane and a limp.

February 23, 2021 I fell on ice in front of my house and badly broke both bones in my leg above my right ankle. The 3 ½ hour surgery to repair the break took place on March 4, 2021.

Following six weeks of non-weight bearing and elevation of my right leg – I worked at home from a rented hospital bed - my first physical therapy appointment took place April 19, 2021. The after effects of the break, which included talus dislocation and soft tissue damage in addition to the broken bones and surgery, also affected my nervous system. My initial Physical Therapy visits involved starting to regain ankle mobility and reawakening of the nerves below my knee as the muscle atrophy from non-weight bearing was extensive (my lower legs still don't match). I walked in the house without crutches, 13 weeks after I fell, starting May 25th.

Each follow-up visit with my surgeon, following his initial referral to physical therapy on my April 13 visit, included either a written referral for PT, or encouragement to continue seeing the physical therapist as my progress was better than expected.

My health insurance is marketed as allowing 50 PT visits per calendar year, per family member. In reality, my physical therapist's office had to send 5 written requests requesting visits. Those requests were sent to a third party who decided how many visits I needed, ie. how many the insurance company would pay for, etc.

When visits started being denied, an internal insurance company policy about how much coverage was available was referenced as the reason for denial. Acting as if they have direct knowledge of my specific case, the insurance company said they would provide a suggested fracture protocol to my PT. The protocol was never made available to my therapist. Thankfully, the care I have received went far above and beyond what was likely the suggested protocol as none of the medical professionals involved in my care have considered my injury a typical broken ankle. I had 2 screws in my tibia and a plate with 9 screws in my fibula. One screw was removed in early December.

My insurance company paid $5,034 for my Emergency Room visit, $2,735 for an MRI, $38,997 for my first surgery, and $5,972 for my second surgery. They stopped paying for physical therapy after $_____. The deductible for our High Deductible Health Plan was $5,000.

I am still not back to normal function in my ankle. The work I have done with my PTs has helped me progress from being unable to walk, to being able to walk unaided. I have not regained full

range of motion, the ability to run, nor am I able to wear women's work appropriate dress shoes. I not only believe my insurance company is wrong in their assessment of my need for care, but I have the means to self-fund my continued care. As a result, in 2021 I paid out of pocket for 23 of the 50 supposedly covered visits plus an additional 4 visits. Seven months after my accident, in addition to lack of mobility, I was still icing my ankle after spending hours on my feet and dealing with ancillary knee pain. Approaching the one year anniversary, I am not running yet, but walking well. I am still going to PT in the hopes of reawakening the remaining muscles in my calf so my legs match.

The majority of patients in my situation would be left with less than optimum outcomes – partial rehabilitation resulting in unresolved physical issues that will only get worse and result in future visits to medical professionals.

Thank you for hearing my testimony today. I hope this committee will use my story as an example of what is broken in the relationship between patient and physical therapist. Coverage for mental health, orthodontics, and PT are outlined in our health insurance enrollment materials. My son, and I both wore braces at the same time, but orthodontics coverage was neither parsed out nor denied. Please help physical therapists help their patients lead more productive lives and support AB 972.

TO: Chairman Sanfelippo and Members of the Assembly Health Committee
FROM: John Hendrickson, PT
DATE: February 16, 2022
RE: Support for AB 972

My name is John Hendrickson. I am a physical therapist and own SPORT Clinic Physical Therapy. We currently have two offices and employ 12-14 people.We have two different clinics in Ozaukee County.

I am a past president of American Physical Therapy Association – Wisconsin and American Physical Therapy Association Private Practice Section, nationally. I have owned and run the my business for almost 38 years. The last 10 years have been the most challenging. As an independent owned health care business, we have survived by doing PT the right way, helping people resolve pain, regain mobility and strength for function. We rely upon word-of-mouth referrals, our marketing team with electronic internet medium reviews and our contracts with commercial payors. It is very common for people to seek us out from the list of providers in their insurance benefit information.

SPORT Clinic is an in-network provider for large inter-state commercial payors including Anthem, Humana, UHC/Optum, and and in state companies like WEA, WPS as well as worker compensation insures. We are a Medicare certified company as well.

Initially I operated the business and told my employees to treat people with respect, good care, bill appropriately to help people get and stay well and that we would be reimbursed appropriately. As the owner it is my job to maintain financial stability, growth and help the employees have good careers. We do those same things now but also have to deal with reducing rates of reimbursement and continual oversight and second guessing on our decision making. The UR and UM process is unnecessary, burdensome and cuts into our bottom line. When Blue Cross&Blue Shield first started to use utilization review, years ago, I was actually treating their Wisconsin Medical Director. He specifically told me about telling the national CEO that we did not need utilization review in Wisconsin because the therapists in Wisconsin did not over utilize. Obviously, his voice was not heard.

Our rate of insurance reimbursement per unit of care is 50% of what is was 10-15 yrs ago. In addition, we have absorbed extra cost on our end to spend time with people and help them understand the benefits of their insurance plan, obtain the authorization for care and re-authorization for ongoing care. This adds to my overhead costs. We always inform our patients to learn about their benefits. It is not uncommon for us to get inaccurate or contrary information to what our patients receive. This creates confusion as to their benefits.

Do they have a co-pay? How much is that co-pay? Have they met their deductible? Does the person understand the difference between a deductible and a co-pay.?
If people have co-pays of $40, $50 and some even $80 per visit, it is often times a limiting factor for them to have ongoing necessary care. This bill would keep co-pays the same as seeing their primary care physician. No confusion. No angst. Something that's easy to understand, follow and be listed on the back of their insurance card.

My staff does their best in our front office to get accurate information to the person we are treating so that they can concentrate on getting well in their recovery. People that come to see us or any Physical Therapist want to be pain-free and move easily for normal daily function. Our job is to help them get to that point. Years ago Insurance companies would advertise that they would help people get back to

their prior level of function following an injury or surgery. Boy are those days gone.
The jest of the UR process is added stress of not knowing whether they have services available to them that they thought they had paid for with their premium dollars. This is particularly true in the waiting process for initial authorization and also for reauthorization for continuation of care without interruption.

People feel "on a roll" with the therapy process and then may have to discontinue or perhaps agree to pay for the skilled care as they await the often, ambiguous UR process.

Issues with this process includes:

1. UMR is telling us we can expect results in 5-15 days from receiving our request for authorization -and we are a Tier 1 provider for UHC! That means for UHC we do not have to get prior authorization. UMR is the company owned by UHC for doing business with self-insured businesses. It is confusing and an unnecessary burden. We receive a per diem rate of only $70/visit for UHC members. That covers about 20 minutes of time with the PT. And, then the UMR wants more staff time for the authorization process. They are unwilling to increase our rate and therefore may need to discontinue the contract and therefore limit accessibility for literally hundreds of patients we have seen in the past and therefore losing their business to other providers. Hospitals and equity base PT companies receive reimbursement on a fee schedule basis. This extra time for the utilization review may force me out of the contract.

2. AIM (for Anthem)
-Request must be submitted online within 48 hours (a burden for our small, part-time staff). If the evaluation is done by PT on a Friday afternoon the auth request is due Monday morning. If the patient is in acute pain we want them to get in for treatment asap but they have to wait. This is frustrating for the patient and the therapist.
-Time consuming for staff to enter information in the online portal.
-The portal collects limited information on the patient's actual condition and on the PT's assessment & treatment plan. (We can put in only one ICD-10 diagnosis code and up to two OMT (outcome measurement tool) scores in their system. They only want limited information, I believe, so they can limit the number of visits for care. This add time for us to continually do requests for reauthorization taking us away from caring for the person. And they usually do not reimburse for the time it takes to get more information to support our case. It seems like they really do not want more information and can then justify limiting the approval for initial and or ongoing care.
-Then there is a short "clinical" questions section, which is difficult for the front office staff to answer independently (this could mean additional time with treating therapist to meet and discuss with the reviewer. This is paid time for the clinic and there is no process for us to be reimbursed for this time.)

I personally was on a call to an AIM PT reviewer for a reauthorization on a person that I had been treating for 8 sessions. That equates to at least 8 hours of time to understand the intricacies of her case and build a relationship of trust. The patient had a reoccurring episode of acute low back pain with a significant clinical presentation and co morbidities of RA (rheumatoid arthritis), post motor vehicle collision, attention deficit delay and a demanding job. She was unable to work a full day and had difficulty walking, getting dressed etc. This was a recurrent problem that had NOT been thoroughly resolved in the past at a different clinic as the insurance had chosen not to allow for continued care. The patient chose to not pay herself. For ongoing care and discontinued the service.
I took the call that morning even though I was working with another patient.

I asked and the reviewer said she was a PT but had not read my notes. I said she should call back after she had read my documentation and that we should set up a time when I was not busy.
The reviewer said it would take 20 seconds to get up to date. I told her she was not going to understand the complexity of the case in 20 seconds after all he documentation I had provided about the complexity of the case. I again stated that she needed to call me back when she had read all my documentation.
The reviewer said that was not going to happen.
This discourse took over 15 min and the reviewer said she get would get back to us in the next 5-7 days.
The patient had to wait for care that was working. Her policy had 25 visits and she had used 8.
We did receive a few more authorized visits but had to go through the process several more times. In the end this patient chose to continue care on a cash basis as she was finally getting better and able to enjoy her life and job being pain free.

It is not uncommon for me or one of the therapist in my practice to do an initial evaluation, determine there are several diagnoses and perhaps several comorbidities that will affect the length of care and how many treatment sessions are required. It is not uncommon for our front desk personnel to try and answer the questions for utilization review only to have to disturb the therapist while treating another patient, to get more information.
If the utilization review people would just read what the therapist wrote in the initial evaluation they would understand the problems the patient is having and not need to use more of our time or their time to determine the plan of care that is appropriate for that insurance companies beneficiary. It would even be better if we had the first 12 sessions without oversight to treat the patient appropriately and establish adequate documentation as to the need for ongoing care, the amount care needed in terms of number of visits over a set amount of time.

Magellan (for WPS and WEA Trust)
-One example of a partial denial was a patient of one of my associates was treating: despite clear documentation that continued care was medically necessary. Magellan determined that frequency should be decreased. On that call they then determined an independent HEP (home exercise program) was appropriate, despite the fact the patient was NOT able to complete mandatory work duties. The patient was progressing and had contract visits available.

-The Results take 5-8 business days from the initial request for authorization despite the documentation of pain and functional limitation.

Kate Lewis just testified and I was the treating therapist. As you heard Kate had an awful ankle fracture injury on 2/23/21, requiring open reduction and internal fixation surgery on 03/04/21 followed by required bed rest.

She started PT weeks later on April 16, 2021. She needed two crutches and was unable to bear weight on that leg.

We asked for 2 visits for 3 weeks and then weekly if she was able to extend R knee fully for wt bearing. They authorized 10 sessions through 6/11/21. We used those visits up by 5/20/21 as Kate was having significant pain, stiffness and difficulty walking.

At one point during her recovery, I did discuss her case with a reviewer who told me that I needed for follow the fracture protocol. I asked for a copy of their protocol and she said I could go online and read. When I tried, I discovered the document was proprietary and I WAS NOT allowed to see the information.

This was at least 30 minutes of my UNPAID time. This was very frustrating as they were following some sort of protocol, perhaps actuarial, and not about patient care and progress or lack of progress due to extenuating circumstances. In other words the fact was noted that Kate had physical therapy benefits per her contract with WEA but was unable use those benefits paid for by her premium payments.

The insurance companies have a contract with their members to help cover the cost of care. In fact the medical cost ratio under the affordable care act states that 85% of premiums needs to go towards patient care. It is alarming that the insurance company can hire or perhaps even own a utilization review company to limit care and that the money spent for that utilization review is considered to be part of the insurance company spending on patient care.
Try explaining that to a patient with severe low back pain and sciatica. They just want our help and guidance to get well.

Other negatives of the UR process:
-We do our best and our EMR assists in alerting the therapist if another progress note/reauthorization is needed, however If we miss an authorization, it is a lot of time and work by front office staff to request retro authorization. The process can be dragged on for weeks or months, and it is not always successful. There are scenarios where we discover this too late and get no payment for services.
-Patient uncertainty & delayed care: patients are hesitant to come to PT if they do not have authorization approved and/or they are left not knowing if they will have to pay for the visit out of pocket.
-Lots of extra unreimbursed time for the clinic staff: The staff and front desk have developed a relationship with the beneficiary yet there is a need for conversation with patients. We need to explain the authorization process, explain why we have not yet received re authorization and help them decide if they should attend their scheduled appointment or not.
-All of the authorization systems are different, and have different requirements.

The insurance companies would save money by allowing the first 12 PT sessions to happen before UR is needed. Most of the time acute problems are resolved by early active PT intervention in the 12 sessions. It is more severe issues like sciatica, cervical radiculopathy and post fractures that do or do not require surgery.

The utilization review and utilization authorization process is time consuming on our end and confusing for patients. It's easy to understand that they have a physical therapy benefit of 20, 40 or perhaps 50 visits per calendar year. They don't understand why if they have paid for that benefit that the utilization review company, that may even be owned by their insurance company, can then decide to limit their access to physical therapy based upon arbitrary information or incomplete information.

Patients rely upon us clinicians to give them the appropriate diagnosis and plan of care that includes skilled care and home programs to follow. We have a code of ethics to follow that specifies we put their needs first.

In my business, our rate of insurance reimbursement per unit of care is about 50% less of what is was 10-15 yrs ago. In addition, we have absorbed extra cost on our end to spend time with people and help them understand the benefits of their insurance plan, obtain the authorization for care and re-authorization for ongoing care. This adds to my overhead costs. We always inform our patients to learn about their benefits. It is not uncommon for us to get inaccurate or contrary information to what our patients receive. This creates confusion as to their benefits.

Do they have a co-pay? How much is that co-pay? Have they met their deductible? Does the person understand the difference between a deductible and a co-pay.?
If people have co-pays of $40, $50 and some even $80 per visit, it is often times a limiting factor for them to have ongoing necessary care. This bill would keep co-pays the same as seeing their primary care physician. No confusion. No angst and something that's easy to follow or print on the back of their membership card.

We all know that during the pandemic hospitals were basically shut down for elective procedures and surgeries. Physical therapy was considered an essential care and business. We at SPORT stayed open. We put UV lights in our air filtration systems and had one therapist dedicated to following CDC guidelines. The premiums that people paid during the pandemic did not change and yet there was less cost for the insurance company and they reported huge record profits during the 2nd and 3rd quarters of 2020.

I know that this is not a state issue but it certainly is an issue that affects all of us in this room. All independent and for-profit corporations want to and need to do well to support and grow their business. What happened legislatively that this cost ratio was not enforced.

In the fall of 2020 Medicare was planning to decrease reimbursement for physical therapy by at least 9% per Congressional mandate. In preparation for our budget for 2021, I requested an increase in reimbursement from each of our commercial payer contracts. None of them increased the rate of reimbursement. It was really impossible for me to reach a provider relations person at these companies. We used to have that communication contact with the payers we have contracts with for us to be an in-network provider. Now, they do not negotiate, the insurance companies just say here is our rate-take it or leave it. The insurance companies have all increased their utilization review and utilization authorization processes, while decreasing the reimbursement of our services and limited our communication.

Our patients just want to have access to the benefits that they have paid for. They want us to help them get better and recover from the shoulder strain that they got from playing softball or golf. They want to come to the clinic as necessary to relieve them from the neck shoulder and arm pain that came from sitting for all of the zoom meetings and computer time that happen to people as a result of the pandemic. They want to learn about how to care for the low back pain that makes it difficult to walk, sit, get dressed or play with their kids.
We know, through post claim research, that the sooner a person with low back pain sees a PT and begins active care, they are less likely to need opioids, scans or surgery. We know early access to PT care for ALL musculoskeletal issues will save time and money for all. Early access to active care significantly limits the number of people developing chronic pain.

However, in my physical therapy business, we have extra burdensome paperwork that takes time and energy away from patient care and decreased reimbursement to the point where there is no profit. AB 936 will help alleviate this problem.

I am a conservative by nature and understand that businesses are to grow and produce a profit. I understand CEO's making a good living as they are responsible to the share-holders and the employees. I do not understand an insurance company CEO receiving a 50 million dollar annual bonus paid for by the premiums we all pay, only to have our care limited.
Why is the stop gap ratio rule not being followed?

In my business we used to be able to provide group health insurance premiums and HSA monies for the employees, contribute to their 401(k) and have a little money to raise their rate of pay on a regular basis. Currently we have had no increase in reimbursement and in fact even since the pandemic we have received lower reimbursement. Hospital reimbursement for the same unit of care as provided by my independent clinic is 3 to 4 times what we get paid. In addition we have to take time away from patient care and use our front office personnel to sift through the maze of utilization authorization and utilization review.

This utilization review process,that has become more prominent with our commercial payers, is burdensome, unnecessary and it limits patients access to good quality care and successful outcomes in a timely fashion. I ask that you support this bill in this hearing, the vote and then champion this cause in both the assembly and the Senate for a quick passage.
end to this time-consuming, and expensive process.

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John Hendrickson PT President SPORT Clinic Physical Therapy Mequon. Cedarburg American Physical Therapy Association (APTA) vision statement: "Transforming society by optimizing movement to improve the human experience."

In Support of Assembly Bill 972

My name is Craig Jankuski, and I am a physical therapist and a member of the American Physical Therapy Association. I am also the Vice President of Rehabilitation Services and Sports Health for the largest health care provider in the state, Advocate Aurora Health. Our team of nearly 1800 physical, occupational, speech therapist, and athletic trainers stretch from Marinette to Racine. In 2021, this team treated over 355,000 residents of Wisconsin in all care settings.

I am reaching out to you today as a physical therapist and healthcare leader to ask for your support of Assembly Bill 972.

This bill is aimed to assist individuals to access covered benefits for the improvement of their overall physical and mental function by reducing the burden of aggressive prior authorizations set in place by commercial insurances for physical therapy services.

In order to provide quality care, timely access to physical therapy is critical. Delay or disruption in the provision of service can result in decreases in the quality of care, increased cost to our patients, and limitations in functional improvement. The average initial evaluation paperwork at my organization has increased to seven pages. Daily treatment notes are now three pages. Most patients will have close to forty pages of documentation before treatment is complete. This is a four-fold increase from just a few years ago. The increase in documentation burden is largely a result of increased requirements of private insurances for pre-authorization of services. This increase in documentation has not bene shown to improve the overall quality of care, nor limit the patient's expense in their care.

In addition to the increased documentation burden to justify care, health care systems are now being asked to input healthcare informaiton into insurance portals. The software is not designed to be compatible with our electric health records resulting in the healthcare providers needing to employ additional resources to input data. We now have a team of twenty at my organization with the soul function of requesting pre-authorization of care. Furthermore, the software does not allow for an explanation of the medical complexity and uniqueness of individuals. Upon completion of the preauthorization process, patients are often left with only a few approved therapy visits. Sequestering additional therapy visits can take up to fourteen days to receive authorization. This causes delays in non-pharmacological care and drives some patients to seek additional resources for pain control. Those delays limit the care patients receive for covered services, increase the overall cost of care, and ultimately impact the quality of life of our residents.

The current appeals process for denials is flawed when it comes to a peer-to-peer review for physical therapy. For some private insurances, a physical therapist is only afforded a two-day window to appeal. This process results often in cancelation of care of other patients to speak with the insurance company. The physical therapist often is asked to speak with another health care professional who is not a physical therapist, resulting in limited ability to discuss the overall complexity of care. Ultimately, this not a peer-to-peer process, but often a decorate level prepared physical therapist explaining care to nurse or medical assistant.

It is for the aforementioned reasons that I am asking for your support of Assembly Bill 972 which will expedite the care of patients seeking non-pharmacological care for the treatment of pain and dysfunction by limiting the administrative burden of the authorization process. Furthermore, utilization review of denied cases should be conducted by same licensed health care professionals.

TO: Chairman Sanfelippo and Members of the Assembly Health Committee
FROM: Dennis Kaster, President of American Physical Therapy Association-WI
DATE: February 16, 2022
RE: Support for Assembly Bill 972

Thank you for taking the time to consider AB 972. I am the president of the American Physical Therapy Association, Wisconsin. I have been a practicing Physical Therapy (PT) for 35 years and have worked both in large hospital settings in urban areas, small hospitals in more rural towns and currently in a private practice in Stevens Point, WI. I have spent the last 35 years helping patients to overcome pain and regain function to enable them to return to normal lives. There is a great deal of research that demonstrates Physical Therapy is extremely cost effective in providing excellent long-term outcomes in decreasing pain and dysfunction. If you are not familiar, PTs figure out what is causing the patients pain or dysfunction, such as muscle weakness or tightness as well as looking at other factors such as how their workstations are set up. We then work with them to perform techniques to decrease their pain, stretch, strengthen or develop ways to modify their environment to put less stress on their bodies. We give them strategies to correct the problem, then self-manage it going forward. As it takes time to teach them what to do, it can take multiple visits to achieve these goals. National data shows approximately 12 visits as an average. I have been here in the past demonstrating how Physical Therapy can help lessen the opioid epidemic, as we can resolve pain without medications. Medications tend to be expensive and usually only give temporary relief, doing very little to resolve the problem. There is a great deal of literature demonstrating that Physical Therapy gets patients back to work quickly, reduces overall healthcare cost and utilization of medications, X-rays and MRIs. I can provide you with a great deal of literature to support what I am telling you if you would like it. We can all agree that the number one goal for all of us is to decrease the cost of healthcare while improving outcomes.

Over the past few years, we are seeing a very disturbing trend where insurance companies are making huge profits by creating barriers for patients to attend Physical Therapy and impose increased costs for healthcare providers while decreasing the payment given for care of their patients. My organization has tried working with these companies to reverse these issues. Our requests have fallen on deaf ears. With many insurances Physical Therapy is categorized as a specialty service, instead of a service equal to primary care. This drastically increases the copays that patients must pay for each visit. On top of higher deductibles many of my patients must pay $40-$80 each time they see me, instead of the $15-$20 they might pay if my visits were at a primary care level. Many of my patients do not make a lot of money and cannot afford these high copays, so they are forced to stop seeing me. At the same time copays for many drugs are just $5 dollars, so many patients are encouraged to take medications instead of getting Physical Therapy. This makes no sense at all at a time when we are fighting the opioid epidemic. In addition, there are many unnecessary authorization requirements that vary greatly between each company and involve a great deal of administrative time to complete and submit. My company devotes approximately 130 hours per week of time devoted to these authorization processes. This is time that could be devoted to patient care. At a time when excellent outcomes may be achieved with a patient in approximately 12 visits, Physical Therapists may be required to submit authorization paperwork several times, for fewer than 12 visits. I recently saw a patient who had been experiencing migraines for many years and was taking expensive medications on a regular basis for his migraines. He was getting daily migraines and missing 1-2 days of work a week due to the migraines. I saw him 11

times over 4 months. His copay for each visit was $70. The copay alone for these visits cost him $770. By the 11th visit he was experiencing less than 1 minor migraine per week, was not taking any rescue medication and was no longer missing any days of work. During that time, I had to send in three requests for authorization. After the 11th visit, Aim, the utilization review company, through Anthem insurance denied any additional care. I appealed the denial and when I discussed the case with the reviewer, who sounded like he was in a different country and reading from a script, he told me it was being denied because I did not have goals that were measurable. When I told him that I measured the number of migraines per week and days off work, he kept repeating the same message about measurable goals and that Aim did not consider pain a measurable goal. The patient was denied any further care by his insurance company.

Our country is spending much more on health care and getting worse outcomes than many other countries in the world. This is crazy. We have the ability and should lead the world in our cost effectiveness and outcomes. The issues we are bringing to light today are examples of why we are lagging behind. Insurance companies are ignoring evidence-based practices. Instead, they are creating bureaucracy that benefits themselves with higher profits and less care for their patients. At the same time the bureaucracy they are creating is increasing the overall cost of healthcare as it increases costs for medical providers to complete the various authorization processes, without reimbursing the providers for this increased cost. We have tried for many years to negotiate with multiple insurance companies to resolve these issues, but they have not been willing to make any significant changes. We are not requesting a total elimination of utilization review, just a process that makes sense, does not create excessive bureaucracy, and allows patients to utilize PT to better resolve their issues and avoid taking medications. Unfortunately, the only way we see to achieve this goal is to legislate some basic guidelines to help injured people in Wisconsin get higher quality care with less cost.

I ask you to please support AB 972 as it is written. Please help us to decrease overall cost of care, improve outcomes and fight the opioid epidemic.

Wisconsin Association of Health Plans

From: Tim Lundquist, Senior Director of Government & Public Affairs
Wisconsin Association of Health Plans
To: Assembly Committee on Health
Re: Assembly Bill 972
Date: February 16, 2022

The Wisconsin Association of Health Plans appreciates the opportunity to provide comment on Assembly Bill 972, legislation relating to prior authorization for coverage of physical therapy and other services under health plans. The Association is the voice of 12 community-based health plans that serve employers and individuals across the state in a variety of commercial health insurance markets and public insurance programs.

Community-based health plans are committed to ensuring their members have access to the right treatment, at the right time, and at a cost they can afford—including physical therapy. Because of this commitment and AB 972's negative impact on processes that ensure patients receive safe, effective, and high value care, community-based health plans are opposed to this proposal.

AB 972 imposes sweeping restrictions on prior authorization for physical therapy services, micromanages what should be contractual issues between health plans and providers, and upends customary health plan cost-sharing and benefit design.

For example, related to prior authorization, the bill does the following:

- Prohibits health plans from requiring prior authorization for the first 12 physical therapy visits with no duration of care limitation.
- Prohibits health plans from requiring prior authorization for any nonpharmacologic management of pain provided through care related to physical therapy to individuals with chronic pain for the first 90 days of treatment.
- Prohibits health plans from requiring prior authorization for coverage of any health care service that is incidental to a primary covered health care service and is determined by the covered person's physician or health care provider to be medically necessary.

Health plans oppose these provisions, as they strip away an important tool to help ensure that patients receive care that is safe, effective, and high value. Prior authorization is both a cost-saving and waste-prevention tool. With a comprehensive view of the health care system and each patient's medical claims history, health plans use the prior authorization process to ensure that treatments prescribed are safe, effective, and affordable to match each patient's health care needs. This results in better outcomes and lower costs for patients.

AB 972 also requires that health plans issue decisions regarding "reauthorization" (a term that is undefined in the bill) of physical therapy services within 48 hours of receiving a request. If an insurer does not issue a decision with 48 hours, prior authorization is

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assumed to be granted for the service. The very concept of "reauthorization" negates the express purpose of the prior authorization process: to ensure that patients access care that is safe, effective, and high value. The value of the prior authorization process is present no matter whether a request is made for authorization or "reauthorization" of services. Further, the bill's 48-hour time limit effectively establishes a requirement that health plans dedicate staff to reviewing "reauthorization" submissions on weekends, for services that are neither urgent nor emergent.

AB 972 even goes so far as to define a new type of health care service ("urgent health care service") in Wisconsin insurance law and add this new group of services, along with non-emergent and non-urgent services, to a long-standing statutory requirement prohibiting prior authorization for emergency medical services.

In addition to gutting a core function of managed care, AB 972 also:

- Mandates the rate and manner by which health plans must reimburse providers of physical therapy services for certain administrative activities.
- Micromanages the operations and communications of utilization review organization and utilization management organization.
- Requires health plans to make physical therapy copayments and coinsurance equivalent to copayments and coinsurance for primary care services.

These provisions inappropriately interfere with both negotiated contracts between health plans and providers, and contractual relationships between health plans and their vendors. The copayment and coinsurance provision would also increase costs and impact member access to safe and effective services.

The Wisconsin Association of Health Plans is opposed to AB 972. For the many reasons described in this memo, community-based health plans respectfully urge committee members to reject this bill.