# NANCY VANDERMEER

STATE REPRESENTATIVE • 70TH ASSEMBLY DISTRICT

TO: Honorable Members of the Assembly Committee on Health, Aging and Long-Term Care

FROM: State Representative Nancy VanderMeer

DATE: November 8, 2023

SUBJECT: Testimony in Support of Assembly Bill 507

Thank you Chairman Moses for holding a hearing on AB 507 today. You and a number of returning members of this committee may remember hearing an almost identical version of this bill during the last legislative session. The primary purpose of this proposal is to call attention to some substantive challenges being experienced by physical therapy and a number of other health care therapy providers throughout the state and subsequently, the delivery of 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 therapy providers. You will have the chance today to hear from a number of health care 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 therapy visits with no duration of care limitation or for any nonpharmacologic management of pain provided through care related to 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 therapy service provider and to the covered individual for a denial of coverage for or reduction in covered therapy services and to compensate 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 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.

Also, 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. As I mentioned last session when I had the chance to testify on this proposal in front of the committee, 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

Wisconsin State Capitol • P.O. Box 8953 • Madison, WI 53708-8953 • (608) 266-8366 • Fax: (608) 282-3670 • Toll-Free: (888) 534-0070
Rep.VanderMeer@legis.wisconsin.gov

NANCY VANDERMEER

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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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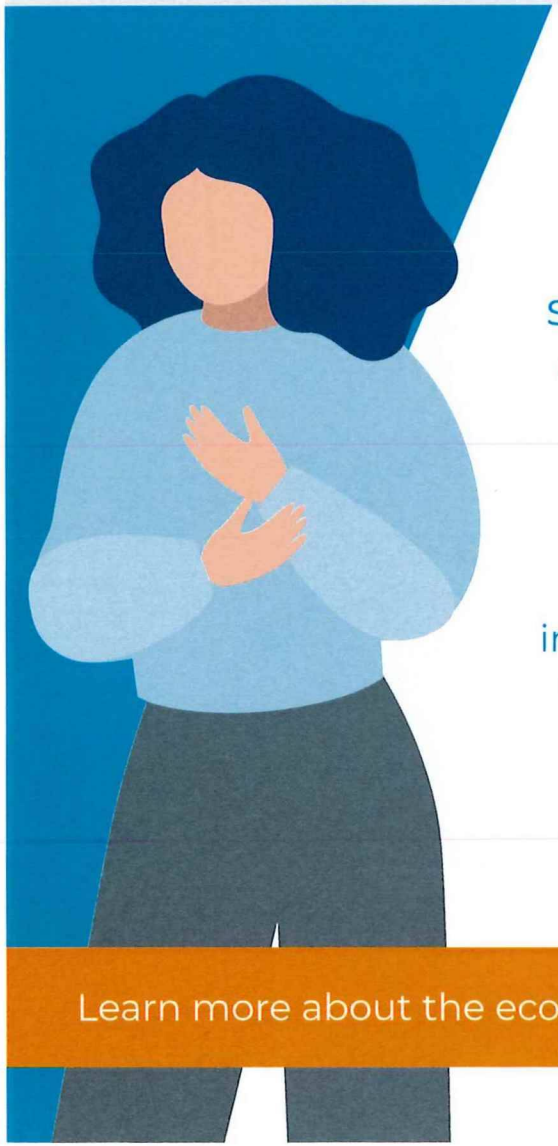
# Physical therapy helps alleviate unnecessary medical costs and potential complications from surgery for patients with carpal tunnel syndrome.

Support policies that expand access to care and coverage for physical therapist treatment of carpal tunnel syndrome.



Choosing physical therapy over surgery to treat carpal tunnel syndrome results in an average net benefit of

**$39,533**

including all the hidden costs of a patient's time, pain, and missed life events; and the dollars paid for the services.

## Physical therapy also helps patients:

**Avoid** unnecessary medical costs.

**Increase** hand and wrist strength while improving long-term function, ultimately contributing to better health.

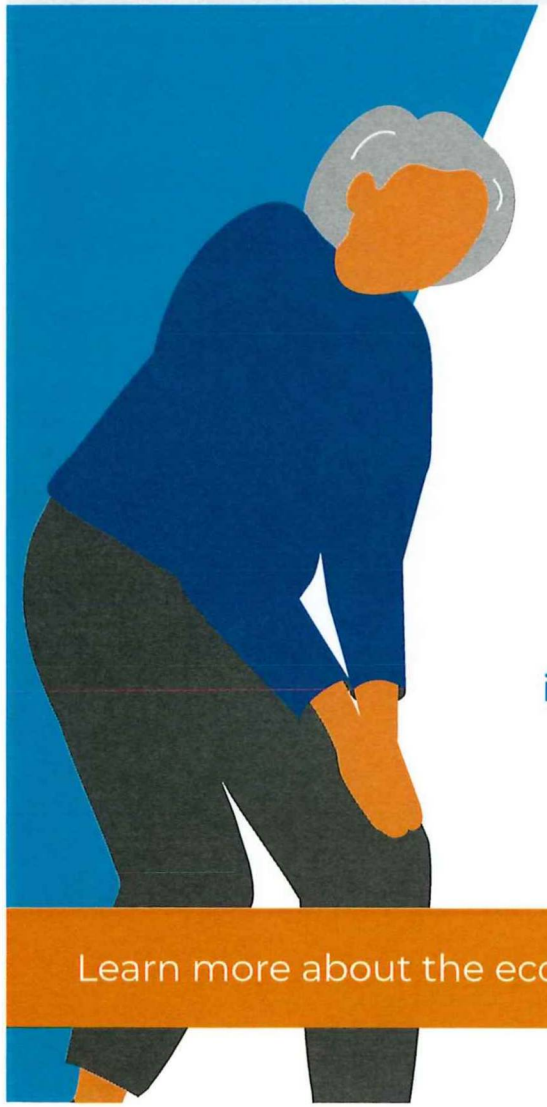
**Reduce** risks of having complications that require health care services down the road.

Learn more about the economic value of physical therapy at **ValueofPT.com**

APTA
American Physical Therapy Association

# Physical therapy provides downstream cost savings by helping patients with osteoarthritis of the knee avoid invasive steroid injections and surgery.

Support policies that expand access to care and coverage for physical therapist treatment of osteoarthritis of the knee.



Choosing physical therapy over steroid injections to treat osteoarthritis of the knee results in an average net benefit of

**$13,981**

including all the hidden costs of a patient's time, pain, and missed life events; and the dollars paid for the services.

## Physical therapy also provides patients with:

**Knowledge** to reduce the risk of opioid addiction.

**Downstream** cost savings by avoiding invasive steroid injections and surgery.

**Long-term benefits** of increased mobility, balance, strength, and flexibility, ultimately contributing to better health and lower risk of having conditions that could require additional health care services down the road.

Learn more about the economic value of physical therapy at **ValueofPT.com**

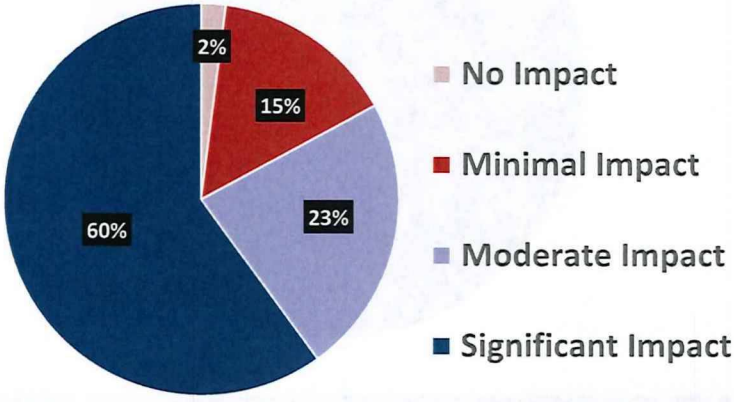
APTA
American Physical Therapy Association

APTA Wisconsin
A Chapter of the American Physical Therapy Association

# 2023 APTA Wisconsin Prior Authorization (PA) Physical Therapy Provider (PTP) Survey

## Patient Impact

**Q:** For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?




**83% of PT Providers** perceive that patients experience a moderate to significant negative impact from prior authorization, including

**60%**

of PT Providers agree that time in testing and meeting additional PA requirements detracts from actual treatment time.

| YES | NO |
|---|---|
| 60% | 40% |

## PA and patient harm

**90%**
**of PTPs**
report that PA has led to gaps in patient care

- **78%** report that PA has led to delays in patient progress
- **52%** report that PA has led to the patient abandoning care
- **45%** report that PA has led to the regression of the patient

## In addition:

# 80% of Patients

report that co-pays and co-insurance ***deters them from receiving medically necessary therapy services***

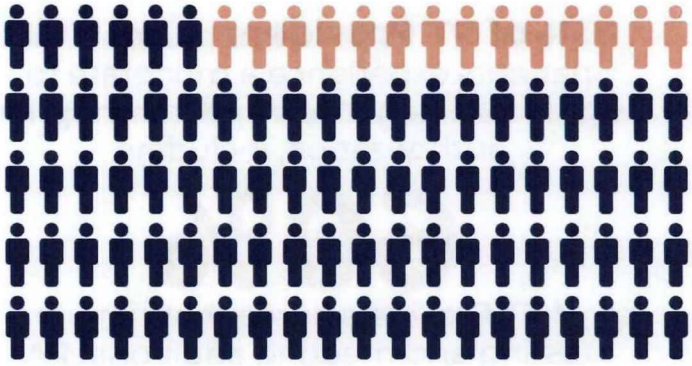
**Survey methodology**

- Twenty-eight question, web-based survey administed March 31-April 24, 2023
- Sample of 358 responses drawn from APTA Wisconsin PT members and associated clinic staff
- Sixty percent physical therapist/40% billing or PA administrative staff member

## PT Provider Impact

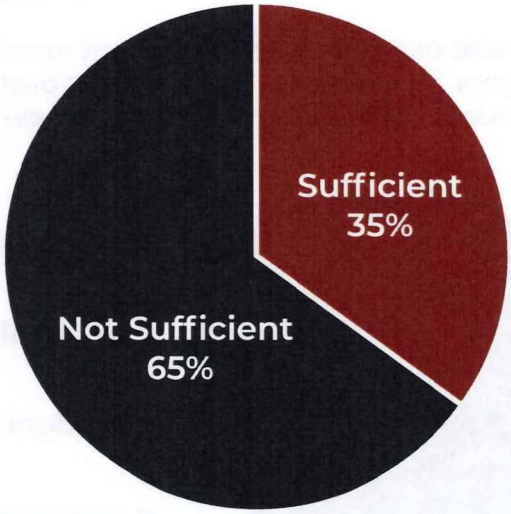
**86%**

of PTPs confirm the initial PA visits are NOT sufficient to complete patient care



**65%**

of PTPs confirm the second PA visits are still NOT sufficient to complete patient care




**Does PT reimbursement match the PA workload?**

**76%** of PTPs say no. The costs associated with prior authorization are increasing faster than the rate of reimbursement.

## A Common Sense Solution:

Since Initial and Second PA visits are nearly always approved and rarely provide sufficient time for a patient to meet their medically necessary Plan of Care, ***Prior Authorization should be deferred to plans exceeding 12 visits.***

For information on APTA Wisconsin's advocacy efforts, visit **https://aptawi.org/members/legislative-issues/**

APTA Wisconsin
A Chapter of the American Physical Therapy Association

To: Chairman Rep Clint Moses and Members of the Assembly Health Committee

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

Date: November 8th, 2023

RE: Support AB 507

Dear Chairman Moses and Members of the Assembly Health Committee,

On behalf of both providers & patients-Thank you for hearing our testimony in support AB 507.

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, from small clinics to rural providers to the largest hospital systems. Many of you have heard from me in February of 2022 on this same issue- And we continue to need your help!

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 diagnose, 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! In fact, more PT often results in less imaging, less surgery, less use of pharmaceuticals and even less doctor visits!

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. The emergence of these 3rd party authorization organizations – known as Utilization Review/Utilization Management (UR/UM) companies – was the result of a loophole in the Affordable Care Act (ACA). Something termed "The Medical Loss Ratio" simply requires that for every dollar spent on insurance premiums, eighty-five cents must be spent on the care of the patient and only fifteen cents on administration and profit. Unfortunately, this loophole allows insurance companies to spend out of the patient's eighty-five cents if they outsource prior authorization. As a result, there is a proliferation of these UR/UM companies that are subsidiaries of insurance companies.

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. We recently surveyed our membership on the effects of Prior Authorization- the infographic you have from APTA-WI reflects how PA affects patient care and our providers ability to deliver cost effective care.

Highlights from the survey include:

- The initial prior authorizations still don't provide enough visits to complete care, creating another two-step process with paperwork to complete care.
- The first 2 authorizations are nearly ALWAYS approved but are insufficient to meet care.
- 90% of providers report gaps in care resulting in delays in patient progress, regression of patient, and even abandonment of care!
- 60% of providers report time in prior auth takes away from time spent in care.
- 80% of patients report that high co-pays deter them from receiving care.

In April of 2023, the United States Congress recognized this problem and passed new legislative guidance *Improving Seniors' Timely Access to Care Act* limiting Prior Authorization for Medicare Advantage patients- "Prior Authorizations are valid for as long as medically necessary to "avoid disruptions in care"." Other states have also moved forward with this process. Maine recently passed a bill to allow 12 visits for PT, OT, SLP & Chiropractice before requiring Prior Authorization. According to the AMA 30 states are in the process of addressing Prior Authorization through legislation.

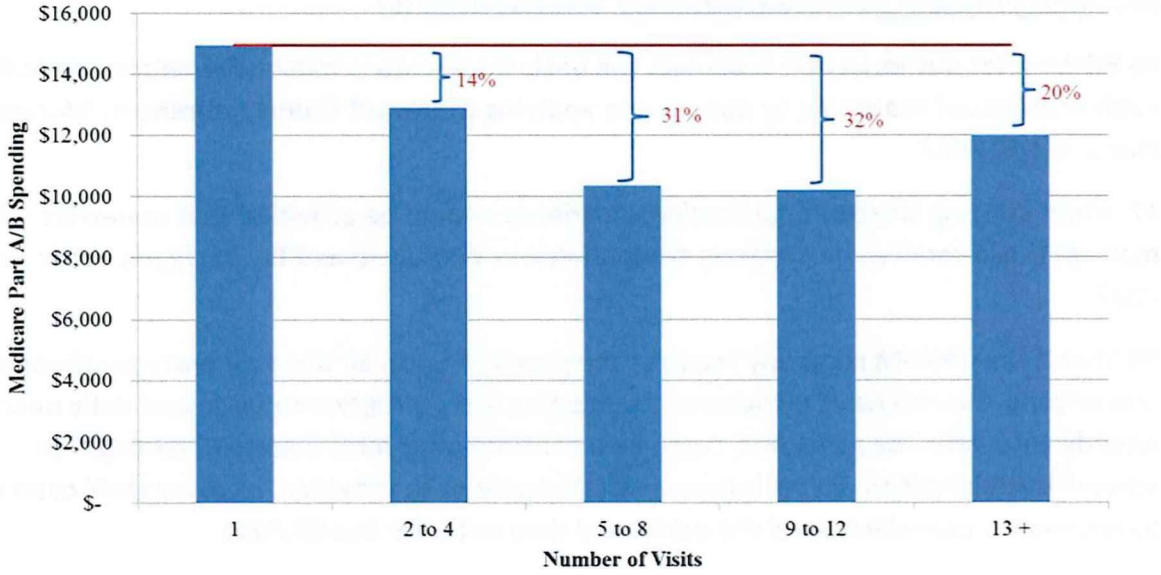
AB 507 is a result of the process getting worse not better despite our best attempts. **AB 507 does not ask that ALL prior authorization be eliminated- the insurers will insist that it is necessary to control so-called "bad actors" in PT.** We are only asking for a reasonable process that allows us to 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 507 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 cover the first two authorizations that are nearly ALWAYS approved anyway! 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! *(See Maine ACTPUB Chapter 275 2023)*

See the chart below by that supports that as PT visits approach 12 the downstream savings to the healthcare system for Low Back Pain- the #1 PT diagnosis. *See: https://www.aptqi.com/Resources/documents/APTQI-Complete-Study-Physical-Therapy-Episodes-Lumbago-October-2017.pdf*

**Figure 1 - Comparing the One Visit Average Total Medicare Part A/B Spending One Year After Incident Low Back Pain (Lumbago) Diagnosis to Other Visit Categories**




These findings suggest that intensity of therapy (as defined by number of visits) is inversely related to total Medicare Part A/B spending.[2] This may signal that physical therapy utilization, as a relatively low-cost option, possibly contributes to less overall spending downstream. This raises important considerations for benefit design and mechanisms to reduce barriers to access physical therapy services. These results are consistent with previous work that found that adherence to recommended active forms of physical therapy results in lower healthcare costs due to lower likelihood of receiving opioid prescription medications, epidural injections, follow-up advanced imaging, follow-up physician visits, and other health resource use metrics without compromising patient outcomes.[3-6]

**#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 the provision of any covered health care service that is incidental to a covered surgical service and determined by the covered person's physician or other health care provider to be medically necessary.** *(See Illinois 215 ILCS 200 Prior Authorization Reform Act https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4201&ChapterID=22#:~:text=(a)%20Notwithstanding%20any%20other%20provision,health%20care%20provider%20of%20that)*

**#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. Delays in approvals lead to delays in care.

**#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. Oregon See: https://oregon.public.law/rules/oar_836-053-1200 (9)**

**#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.** *Michigan Public Act 60 2022.*

**#7 When utilizing UR/UM organizations, evidence should be provided that reviewers who manage these services be properly credentialed in Wisconsin as PTs.** *Michigan Public Act 60 2022.*

**#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, Occupational & speech therapy services to be consistent with primary care copays rather than specialists.** Therapy is not a onetime consult visit -like a neurologist but instead a multiple visit service that should not be disincentivized by charging unreasonable copays. See: *https://www.wvlegislature.gov/Bill_Text_HTML/2023_SESSIONS/RS/bills/hb2436%20sub%20enr.pdf*

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

My name is Dr. Joe Kucksdorf. I am a doctor of physical therapy and the Team Leader of Clinical Quality and Professional Development for Bellin Health Sports Medicine and Orthopedics, in Green Bay, WI.

I have been practicing for 13 years. I am a board-certified orthopedic specialist, and fellowship trained in orthopedic manual physical therapy. A large part of my responsibility is helping guide the quality of care for the over 100 therapists at Bellin Health, providing care to the people of Northeast Wisconsin and Upper Peninsula of Michigan. A core philosophy of ours is providing our patients the highest **value** healthcare. To do so we must be able to provide not only the most effective care, but also the most **efficient** care possible.

One of the arguments we have heard third-party payers make, justifying the need for prior authorization, is without prior authorization in place, therapists will consistently over-use therapy visits. While those situations may occur, I assert they are rare, and our quality data opposes those statements. From 2010 through 2022 we tracked the number of visits from 74,235 individual patient episodes of care. The average number of visits for those encounters was 8 with a standard deviation of 6. That means the vast majority of episodes of care raged between 2 and 14 visits, a reasonable range for a wide variety of health conditions. I believe this to be the norm for the vast majority of therapy practices at Bellin Health and beyond.

For the last four years Bellin Health has offered its employees access to outpatient rehabilitative physical and occupational therapy services free of charge, covered 100% by Bellin Health. The free therapy, called Bellin First, does not have visit limit, co-pay, or prior authorization requirements. We tracked outcome data on Bellin First therapy benefits for 12 months, studying the effectiveness and efficiency of the care. During those 12 months we tracked 114 Bellin First episodes of care. The average number of visits per episode was less than 10. The data shows allowing patients and therapist's autonomy, free of burdensome prior authorization, that they have the ability to provide effective and efficient, high-value healthcare.

Another aspect of quality care we would like to point out is the use of validated health outcome measures. Outcome measures allow clinicians to assess a patient's response to care and routinely required by insurance companies in the prior authorization process. We do not have an issue with insurance companies asking for therapists to justify the number of visits or looking for the use of outcome measures as part of their care and/or documentation. What we do have an issue with is insurance companies making the process overly burdensome, dictating what type of health outcome measures we use, and when we use them. Therapists are educated and skilled in choosing the most appropriate outcome measures to employ with their patients. Prior authorization requiring specific measures or limiting the measures available increases burden on patients and therapists. They require therapists to measure outcomes for the purposes of insurance authorization only, which may or may not be appropriate for the specific patient's care needs. This translates into patients paying for prior authorization paperwork instead of the care they need.

As a specific example, at Bellin Health, we choose to change to collecting Patient Reported Outcome Measurement Information System (PROMIS) family of outcome measures. We choose to move to the PROMIS measures over traditional 'legacy' measures because they

psychometrically sound, validated by research, adaptable to a wide variety of patients, and less burdensome (shorter) than traditional measures. We were driven to use the most effective and efficient outcome measures possible as part of our patient care and quality improvement work. However, we quickly found some of the large third-party payers did not recognize the PROMIS measures, leading to difficulty implementing the measures in the prior authorization process. It is frustrating and challenging when clinicians, who are best suited to choose the most relevant health outcome measures, are unable to use the measures they feel most appropriate to guide (and justify) care. It forces a clinician to adjust to meet the needs of payers over the needs of the patient.

Finally, at Bellin Health, we employ 6 individuals who are dedicated to physical and occupational insurance authorization work. A large majority of their work is managing prior authorization. While those 6 individuals are valued members of our healthcare team, their 6 salaries would be better suited providing value-added healthcare services elsewhere in the health system. Currently, their salaries contribute to increasing cost of care just to manage an ever growing and burdensome prior authorization processes.

As health care professionals, therapists pride ourselves on providing high value and ethical care, acutely aware of the high costs of healthcare. AB-507 makes important steps to limit the burdensome and low-value prior authorization process, increases the freedom for patients and clinicians to provide effective and effective healthcare.

Thank you for your time and attention.

Joe Kucksdorf, PT, DPT
*Board-Certified Clinical Specialist in Orthopedic Physical Therapy (OCS)*
*Fellow of the American Academy of Orthopedic Manual Physical Therapists (FAAOMPT)*
Team Leader of Clinical Quality and Professional Development, Bellin Health Sports Medicine and Orthopedics, Green Bay, WI

1205 Lois Ave.
Brookfield, WI 53035

November 8, 2023

Assembly Committee on Health, Aging, and Long-Term Care
417 N Main St.
Madison, WI 53703

Dear Chairman Moses and Members of the Assembly Committee on Health, Aging, and Long-Term Care,

I am writing to express my strong support for 2023 Assembly Bill 507. As an occupational therapy practitioner with years of dedicated service to improving the health and functional abilities of individuals across the lifespan, I have witnessed firsthand the critical importance of timely access to occupational therapy services.

The current system of prior authorization for occupational therapy services has too often created unnecessary barriers, causing detrimental gaps in the provision of care for my clients. Delays in reauthorization have led to a regression of skills and/or loss of progress that had been hard-won through consistent effort, continuity of care, and professional skilled intervention. This not only impacts the well-being of our clients but also places an additional emotional and financial burden on families and caregivers.

Assembly Bill 507 represents a significant step in ensuring that necessary care is not interrupted and acknowledges the importance continuity plays in care management for clients. This step also acknowledges the essential role occupational therapy plays in the provision of skilled services during the developmental or recovery processes.

In my practice, I have seen cases where clients, particularly children and seniors, suffered due to the lapse in services. The regression in skills for a child with developmental delays or a senior client working to regain independence is not just a temporary setback. The lapse in services can have lasting consequences that extend beyond the individual impacting families and the broader community. Timely care is not a luxury; it is a necessity for improvement of health, function, and quality of life.

The passage of Assembly Bill 507 would be a testament to Wisconsin's commitment to the health and well-being of its citizens. It would also serve as an acknowledgement of the vital role occupational therapists play in the healthcare system, and the need to support them in providing uninterrupted, high-quality care.

Thank you for considering my support for this bill. I urge you to pass this legislation which will have a positive impact on many lives.

Sincerely,

Jennifer L. Kinkade, OTD, OTR/L
Occupational Therapist
kinkadej@mtmary.edu

Testimony for AB 507 before Committee on Health, Aging and Long-Term Care

November 8, 2023

Dear Committee Members;

I urge you to support AB 507 relating to prior authorization (PA) for physical therapy (PT), occupational therapy (OT), speech therapy, and chiropractic services.

The PA process limits patients in Wisconsin from receiving medically necessary physical therapy care, leading to poorer outcomes. It also creates undue administrative burden for providers. You have the results of the survey of physical therapists (PTs) in Wisconsin conducted in the spring of 2023, which shows overwhelmingly that:

- the number of PT visits granted is not sufficient for patients to reach their physical therapy goals
- gaps in physical therapy care due to waiting for the insurance company to authorize visits delay progress and even cause regression in the patient's status
- patients stop coming to PT altogether
- PA takes PTs away from patient care
- facilities have to hire more non-clinical staff to accommodate the additional administrative burden.
- reimbursement for PT services does not cover the administrative costs of PA

Pursuing legislation was not the first solution we sought. APTA Wisconsin has met frequently with insurance companies over the past 3+ years. The result is that some concerns are partially addressed, only to have new requirements arise.

Further complicating the issue is that each insurance company has their own PA policies and processes, requiring providers to master several different systems, and new utilization review companies spring up frequently. We are not advocating elimination of prior authorization. However, we do need a legislative solution to provide reasonable guidelines for PA processes across all insurance companies. Wisconsin is not alone in seeking a solution legislatively. According to the American Medical Association, as of May 2023, nearly 90 prior-authorization reform bills have been considered during this legislative session across 30 states.

Wisconsin insurers have stated that creating reasonable guidelines for the prior authorization process for PT, OT, Speech, and chiropractic services in WI will result in increased rates. However, other states have created legislative standards for the PA process specifically for physical therapy, including Oregon; Georgia; Iowa; Louisiana; Michigan; and Maine; and there is no data linking those standards with health insurance rate increases in those states. A paper published in 2019 ( https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf) summarizing the use of prior authorization policies for coverage of health care goods and services and reviewing the evidence on cost and quality impacts of these policies stated that 'research has not yet definitively established the net economic impact of PA across all system costs and benefits'. In addition, standardization of the PA process across payers was listed as one of the ways to improve prior authorization. Wisconsin is a 'use and file' state regarding insurance rates, meaning insurers must tell regulators about rate increases only when they go into effect, or soon thereafter. They don't have to explain why the rates have increased. Without transparency regarding the reasons for health insurance rate increases, the claim that creating

reasonable guidelines for the PA process in Wisconsin will increase rates is indefensible and without merit.

Another important element in this legislation is to limit any required co-pay to no more than that for a primary care physician. Many insurance plans charge patients the much higher copay that is associated with seeing a physician specialist, like a neurologist or orthopedic surgeon. Charging the same co-pay for PT, which patients need to attend 2-3 times per week for several weeks, as to see a physician specialist that the person may only need to see 2 or 3 times in total, is a huge barrier to patients getting the PT care they need. Our survey showed that in Wisconsin, 80% of patients report high co-pays deter them from receiving medically necessary PT services. We want patients to get the PT need for many reasons, not the least of which is it SAVES MONEY! The American Physical Therapy Association commissioned an international management consultant to examine the costs and benefits of eight condition-based physical therapist services, each of which was chosen based on the prevalence of the condition and its associated level of healthcare spending across the United States. The study compared physical therapist services and non-physical therapist treatments, based on the costs associated with providing care and the benefits generated within the American health care system. Physical therapy was found to have a net economic benefit over the alternative treatment for each of the conditions. I have given you handouts explaining the results of two of these conditions; knee arthritis and carpal tunnel syndrome. A course of physical therapy for knee arthritis resulted in a net benefit of $13,981 compared to getting a cortisone injection. Physical therapy for carpal tunnel syndrome resulted in a net benefit of $39,533 compared to having surgery. Getting people to physical therapy saves money, and high co-pays are a huge disincentive.

In summary, this bill aims to reduce barriers to patients receiving the medically necessary PT, OT, speech, and chiropractic services to which they are entitled within their insurance plan, and it aims to create reasonable guidelines that diminishes the outlandish administrative burden under which providers currently struggle. Please support AB 507.

Thank you,

Dr. Susan Griffin, PT, DPT

President, Wisconsin chapter of the American Physical Therapy Association (APTA WI)

WISCONSIN SPEECH-LANGUAGE PATHOLOGY and AUDIOLOGY ASSOCIATION

*563 Carter Court, Suite B | Kimberly, WI 54136 | 920-560-5642 | 920-882-3655 FAX*

Date: November 8, 2023
To: Assembly Committee on Health, Aging and Long-Term Care
Re: Assembly Bill 507 relating to prior authorization for coverage of physical therapy, occupational therapy, speech therapy, chiropractic services, and other services

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Chairman Moses and members of the committee thank you for the opportunity to submit testimony in support of Assembly Bill 507 which seeks to reform several areas of the prior authorization process for speech therapy and other health care services. While prior authorization has a role in the healthcare delivery system the reforms proposed in Assembly Bill 507 will streamline the process to alleviate unnecessary administrative burdens on providers, and most importantly ensure patients receive timely access to the care they need.

Services delivered by our members span **critical** functioning areas across eating, communicating, and cognition. Unneeded barriers that impede access to timely and comprehensive services can directly impact individuals' progress whether their issues are life-long or acquired in nature. The processes of requesting prior authorizations and their adjudication are time intensive for clinicians and can be frustrating for patients waiting for much needed services.

Children with developmental disabilities such as autism, cerebral palsy, and genetic syndromes benefit from early intervention to capitalize on brain plasticity and developmental windows that maximize their learning potential. As these children age, outcomes in the areas of communication, sensory, and motor skills tend to worsen or become stagnant without adequate intervention to address ongoing therapy needs. Denials or delays in approval of therapy services significantly negatively impact access to critical services that help address the needs of children with developmental delay or disability.

Similarly, and even more urgently, individuals with neurodegenerative or progressive conditions such as muscular dystrophy or Sanfilippo syndrome, do not have time to wait for access to these essential therapy services. Their diagnoses will progressively diminish their communication, sensory, and motor skills, and these patients **must** receive skilled care urgently to maximize their potential and maintain their skills as long as possible.

AB 507 aims to streamline the prior authorization process in several areas including creating more clarity and transparency about the evidence-based policy information that utilization review organizations and utilization management organizations (UR/UM) use to review requests for prior authorization. Just as providers are charged to maintain their knowledge and use of current research to guide their practice with patients, peer review staff should also be governed by and licensed under these same principles. Well-trained review staff and transparency about coverage requirements and the use of medically appropriate and evidence-based policy are essential to allow providers to efficiently address the necessary information for peer reviews to be completed in an appropriate and timely manner.

WSHA fervently supports this effort to reduce obstacles for our patients who seek to improve across the crucial aspects of life. We urge you to support this measure to improve our patient's access to care in an efficient manner, thereby directly impacting their safety, quality of life, and independence.

AHI
ALLIANCE OF HEALTH INSURERS

To: Chairperson Moses
Members, Assembly Committee on Health, Aging and Long-Term Care
From: Rebecca Hogan, Lobbyist
Date: November 8, 2023
Re: Please oppose Assembly Bill 507, relating to prior authorization for coverage of physical therapy, occupational therapy, speech therapy, chiropractic services, and other services under health plans

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The Alliance of Health Insurers (AHI) is a non-profit advocacy organization representing commercial and local health plans in Wisconsin. Our members collectively provide coverage to more than 3 million Wisconsinites through public and private insurance programs, including two-thirds of enrollees in Badger Care Plus and SSI-Medicaid (Wisconsin's Medicaid managed care programs). Member plans are dedicated to delivering affordable, high-value care to the state's commercial and Medicaid populations.

AHI is opposed to Assembly Bill 507. While health insurance plans across the country are reviewing and making their own changes to the prior authorization process, there should not be a "one-size-fits-all" mandate put on plans as prescribed in this legislation. Prior authorization is one tool used by health plans to determine medical necessity for services, and promotes a system of checks and balances that helps keep care more affordable for our members. This bill will make health care even more expensive and more difficult for Wisconsin's employers to provide their employees.

AB 507 prohibits requiring prior authorization for the first 12 physical therapy, occupational therapy, speech therapy, or chiropractic visits. Unilaterally mandating 12 visits for all four of these providers would be a significant move away from what is medically necessary. At the end of the day, every episode of care is different. There are certainly examples where 12 visits are medically necessary and approved for physical therapy or occupational therapy for rehabilitative visits. However, this is not true for all cases across all provider groups, and automatically prescribing 12 for every episode of care will lead to overutilization. For example, data from one of our member plans shows that 45% of all episodes of care require 8 or fewer visits. If this bill were to pass, there would be no incentive in those episodes of care to use fewer than 12 visits, so we would expect an increase in services, some potentially unnecessary.

AB 507 prohibits requiring prior authorization in chronic pain cases for the first 90 days, giving providers the ability to prescribe a wide range of options that may not be the best first choice for managing pain (for example, installation of a pain pump). Barring an insurer from asking for

prior authorization curbs a plan's ability to manage appropriate care. Without this review, there is no ability to discern whether there are more effective and/or affordable methods of care.

AB 507 requires insurers to pay compensation to providers for time spent entering information required during the prior authorization process. It is AHI's perspective that one of the reasons this bill has been presented is because of what the providers say is an unreasonable administrative burden. The administrative burden imposed on both the insurer and the provider to make this workable will offset any revenue gained by the provider. This concept also removes any incentive for staff to work quickly or become better trained to use prior authorization portals correctly.

AB 507 prohibits prior authorization for coverage of any covered health care service that is incidental to a covered surgical service and determined by their provider to be medically necessary, and any covered urgent health care service, as defined in the bill. This will greatly expand the services the health plan has approved. There is no incentive for the physician to be thoughtful about exactly how many visits to prescribe, leading to overutilization. Letting the member's physician determine medical necessity sets a bad precedent.

AB 507 requires that a decision on reauthorization of coverage for a service for which prior authorization was previously granted be made within 48 hours, or prior authorization is assumed. This turnaround time frame is unreasonable. Re-authorization for additional visits is needed because it is likely a patient's medical condition has changed between the initial prior authorization request and the request for reauthorization. Health plans will need sufficient time to review clinical information to make sure subsequent visits match the needed care. While most approvals for reauthorizations happen within 48 hours, is not a reasonable timeframe in every case, especially those that are more complex. Additionally, assumed approval after 48 hours effectively erodes the entire prior authorization process because there is no incentive for a provider to make sure the authorization request is complete or thorough when submitted.

Please oppose AB 507. Each of these provisions will increase the overall cost of health insurance and will make it even more difficult for employers to offer affordable health care coverage in the state of Wisconsin.

If you have any questions after today's public hearing, please contact me at 608-258-9506.

Wisconsin Association of Health Plans

From: Tim Lundquist, Senior Director of Government & Public Affairs
Wisconsin Association of Health Plans
To: Assembly Committee on Health, Aging and Long-Term Care
Re: Assembly Bill 507
Date: November 8, 2023

The Wisconsin Association of Health Plans appreciates the opportunity to provide comment on Assembly Bill 507, legislation relating to prior authorization for coverage of physical therapy, occupational therapy, speech therapy, chiropractic services, 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 the services referenced in this bill. Because of this commitment and AB 507'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 507 imposes sweeping restrictions on prior authorization for many 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, occupational therapy, speech therapy, or chiropractic visits with no duration of care limitation.
- Prohibits health plans from requiring prior authorization for any nonpharmacologic management of pain to individuals with chronic pain for the first 90 days of treatment.
- Prohibits health plans from requiring prior authorization for coverage of any covered health care service that is incidental to a covered surgical 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, and match each patient's health care needs. This results in better outcomes and lower costs for patients.



10 E Doty Street, Suite 503
Madison, WI 53703
www.wihealthplans.org
P: (608) 255-8599
F: (608) 255-8627

AB 507 also requires that health plans issue decisions regarding "reauthorization" of physical therapy, occupational therapy, speech therapy, and chiropractic services within 48 hours of receiving a request. If an insurer does not issue a decision with 48 hours, prior authorization is 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 507 even goes so far as to define a new type of health care service ("urgent health care service") in Wisconsin statute 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 507 also:

- Mandates the rate and manner by which health plans must reimburse providers of physical therapy, occupational therapy, speech therapy, and chiropractic services for certain administrative activities.
- Micromanages the operations and communications of utilization review organizations and utilization management organizations.
- Requires health plans to make physical therapy, occupational therapy, speech therapy, and chiropractic service 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 507. For the many reasons described in this memo, community-based health plans respectfully urge committee members to reject this bill.

Aurora Health Care

Now part of ADVOCATEHEALTH

**Testimony to the Assembly Committee on Health, Aging and Long-Term Care**
**Support for Assembly Bill 507**
**Craig Jankuski, Vice President of Rehabilitation Services and Sports Health**
**November 8th, 2023**

Thank you, Committee members for holding this hearing today. My name is Craig Jankuski, and I am a physical therapist, a member of the American Physical Therapy Association, and a member of the American College of Healthcare Executives. I currently serve as the Vice President of Rehabilitation Services and Sports Health for Aurora Health Care.

Aurora is the largest health system in Wisconsin and a national leader in clinical innovation, health outcomes, consumer experience and value-based care. We serve patients across 17 hospitals and more than 150 sites of care, 80 of which provide physical therapy. I lead nearly 1,800 physical, occupational, speech therapists, chiropractors, and athletic trainers who provide care for 400,000 patients stretching from Crivitz to Kenosha. We provide world class care in concert with over 3,900 of our physicians in Wisconsin alone.

I was in this room over a year and a half ago asking for support to improve our patients' access to their covered benefits. Excessive utilization review has limited access to care to a point that it is unsafe. Unfortunately, over that time little has changed for the better for our patients. That is why I am here today. I am again asking for this committee's support of Assembly Bill 507.

Timing of physical, occupational therapy and chiropractic care is critical to ensure good outcomes. This is particularly important during post-surgical care. Physicians and therapists work in concert to create protocols that require physical therapy at specific moments in the healing process. If the window of care is missed by even one day in certain circumstances the result can be a failed surgery or permanent loss of function. When utilization review is too restrictive, therapists miss that window of care. In Wisconsin insurances can take up to 14 days to perform utilization review. We cannot care for those patients during that time. That delay in care can traumatic and irreversible to our patients.

Secondly, Wisconsin is a state is becoming known for a challenging environment in terms of utilization review. The average total duration of care for a patient ranges between eight to twelve visits. In Wisconsin some insurances only authorize two visits on re-authorization before taking fourteen days to perform utilization review only to authorize two more visits. This makes the therapy far less effective and stretches the patient's care out from weeks to months.

In addition, some insurances require therapists to speak directly with utilization reviewers with little to no notice. To make that meeting possible, therapists often need to cancel other patients, further delaying their care. Our therapists are needed to provide care to our patients - not to process repetitive insurance requests! This restrictive form of utilization review is known by therapists in the market and I am convinced it is causing many to leave Wisconsin to practice in other states.

It is for the aforementioned reasons that I am asking your support of Assembly Bill 507 which will improve the process for patients seeking better access to their covered benefits. We have the ability to help our patients and now is the time to act. Thank you for your time today.

UWHealth

Contact: Connie Schulze
Director, Government Affairs
104 King Street, Suite 303
Madison, WI 53703
608/516-2552 mobile
cschulze@uwhealth.org

Assembly Committee on Health, Aging and Long-Term Care
Testimony supporting AB507
Provided by Kristen Traino
Director of Ambulatory Operations - Outpatient Rehab Services, UW Health
November 8, 2023

Dear Chairman Moses and Members of the Committee:

Thank you for the opportunity to appear before you today to express support for Assembly Bill 507 (AB507). I am Kristen Traino, Director of Ambulatory Operations overseeing Outpatient Rehab Services for UW Health where my work intersects with patients seeking Rehab Services (physical and occupational therapy services, SLP and Orthotic and Prosthetic services) every day. In fact, in my 28 years as a practicing PT, 26 years have been with UW Health, 13 years as the Director of Rehabilitation. Over this time, I have seen the demand for Rehab services increase dramatically, and the burden on therapists to obtain prior authorization grow exponentially to adequately meet the patient need. Assembly Bill 507 would make accessing that care less burdensome and costly for patients and would greatly reduce the frustration experienced by providers seeking to serve patients quickly and efficiently.

Specifically, AB507 would make the following reforms:

- Prohibit requiring prior authorization for the first 12 physical and occupational therapy, SLP, other Rehab therapy visits.
- Prohibit requiring prior authorization in chronic pain cases for the first 90 days.
- UR/UM companies – 3rd party reviewers – shall not use claims data as evidence of outcomes to develop their approval policy.
- Any denial or reduction of services must reference the applicable payer policy and include an explanation for the denial.
- Copays for Rehab visits shall be aligned with primary care copays.
- Providers shall be compensated for time spent entering information required for the UR/UM authorization.

While we understand it is important to employ cost control measures in healthcare, the prior authorization process often has the opposite effect. For example, one in three physicians blamed prior authorization for a patient's serious adverse event, including hospitalization, permanent impairment, or death, according to a survey published by the American Medical Association (AMA) in March of this year. In addition, 86% of physicians surveyed said prior authorization rules led to greater use of healthcare resources overall, and 35% of physicians surveyed had staff whose sole job was managing prior authorization requests. Furthermore, the prior authorization process is often named as contributing to clinical workforce burnout as the process has gotten more burdensome in recent years.

In current state, delays waiting for prior authorization review and approvals result in delayed plans of care and

in some cases abandonment of treatment.
Short turnaround requests for prior authorization or repeated testing intervals by Utilization Management (UM) interrupt the therapy plan and are not reliable as a standard testing measure cycle.
Prior Authorization/repeated testing in a short time frame is likely not going to show enough neuromuscular progress and may delay authorization of the plan of care.
If UM has the goal of using repeated testing and claims data to make determinations regarding progress or meeting goals, this is not an evidence-based approach to care when done in a period of less than 12 weeks. Claims data alone is not an adequate way to assess progress. Billing codes on claims do not clearly paint a picture of a patient's progress toward their goals.

The changes to prior authorization proposed in AB507 will benefit therapy patients! Granting the first 12 rehab therapy visits without prior authorization will allow therapists and patients the **needed** visits to establish the plan of care, and make progress, or to meet their goals and potentially never need to engage prior authorization prior to discharge.
If the prior auth' request is within too short of a time frame or too few visits, it becomes very difficult to schedule visits and maximize the time between when prior authorization is required. Neuromuscular change, which is the goal in standardized testing is not expected in a short time frame of 2-4 weeks.

Passing AB507 can correct factors previously leading to denials of care for patients with expected improvement in therapy but were not given the time to show improvement. AB507 can correct delays in care waiting for prior authorization or premature denials, decreasing patient abandonment of care and chronicity of symptoms, improving outcomes, and ultimately leading to decreased costs to the system. Research has shown these patients who abandon care often continue to utilize emergency care, urgent care and advanced imaging.

At the end of the day, we all want what is best for patients and it is clear reforms around prior authorization are needed to achieve that goal. Our special thanks to the members of the committee who have already expressed support for AB507 including Rep. VanderMeer who is leading this legislation in the Assembly along with some of her fellow health committee members including representatives Brooks, Gundrum, and Magnafici who have signed on as co-sponsors. We hope you see fit to join them and will support AB507 with your "yes" vote.

Thank you for your consideration. I'd be happy to take questions at this time.

Kristen Traino MS PT
*She, Her, Hers* *What are personal pronouns?*
Director Ambulatory Operations
Administration Office Building (AOB)
Suite 420
7974 UW Health Court
Middleton WI 53562
Phone 608-263-8088
Mobile 608-516-9039
ktraino@uwhealth.org

UWHealth

References:
1. https://www.medpagetoday.com/primarycare/generalprimarycare/103515
2. AMA prior authorization (PA) physician survey | AMA (ama-assn.org)

*Good morning, Representative Clint Moses and members of the Committee on Health, Aging, and Long-Term Care. My name is Heidi Weidner. I live in Muskego, WI. I have been a licensed Physical Therapist in Wisconsin for nearly 19 years.*

*I support Assembly Bill 507.*

*Today I am not only testifying as a physical therapist who has had too many disappointing outcomes with the PA process , but as a patient and consumer of healthcare.*

*The prior authorization process placed a large financial burden on me, required hours of frustrating navigation of my insurance plan and resulted in the premature discontinuation of necessary care.*

*I am self-employed. My healthcare literacy is above average. I choose my health plan wisely and have paid hundreds of dollars every month in health care premiums for the last 14 years. I have a $10,000 deductible which I paid to surgically repair my medial meniscus. My insurance benefit for Physical Therapy is 50 visits per calendar year. My surgeon's protocol for the rehabilitation of meniscus repair includes Physical Therapy intervention for the 6 months following surgery.*

My surgery was on April 26, 2023. I had my first PT visit on May 11, 2023 and the insurance company authorized 8 visits, which I completed over the next 4 weeks. On June 1, my PT filed more paperwork and 10 more visits were granted. On July 13, my PT filed more paperwork and coverage was denied.

*Because of the Prior Authorization Process my physical therapy was discontinued before I was strong enough to walk down stairs. National Imaging Associates, the company that denied covering more visits, refused to follow their own appeal process. After my PT submitted multiple progress reports, and took up not only her valuable time but that of the support staff, National Imaging Associates denied my physical therapist the opportunity to dispute their decision in their Peer-to-Peer process. I even paid out-of-pocket for a physical therapy session just so that a more robust battery of tests and measures could be submitted for the appeal.*

*My health insurance company failed to follow their own grievance process. The contact information they provide for their grievance department is an inactive number. After many dead-ends, I was able to schedule a grievance call on August 23, 40 days after my last covered PT appointment. I cleared my calendar and prepared my arguments. My insurance company*

*"panel of experts" never called. Upon reaching my contact at Dean Health Plan, I was told "you should be receiving a letter in the mail in 2 days approving more visits". Interestingly, my plan had just renewed and I was back to paying my $10,000 deductible.*

*I urge you to vote in favor of Assembly Bill 507.*

*The citizens of WI need to be protected against these deceptive business tactics. The average citizen does not have the healthcare literacy and gumption to take on the smoke and mirrors maze that I navigated.*

*Thank you for the opportunity to speak in support of Assembly Bill 507. I'm happy to answer any questions.*

WISCONSIN OCCUPATIONAL THERAPY ASSOCIATION

November 8th, 2023

Assembly Committee on Health, Aging, and Long-Term Care
417 N Main St.
Madison, WI 53703

Dear Chairman Moses and members of the Assembly Committee on Health, Aging, and Long-Term Care,

My name is Nicole Boyington. I am the current president of the Wisconsin Occupational Therapy Association (WOTA). I am here today in support of AB 507 for Occupational Therapy (OT) practitioners in the state of Wisconsin and as a mom.

Occupational Therapists help people get back to their functional activities. After an illness, developmental delays, or injury someone may need help caring for themselves or their family. Most of our clients cannot return to their preferred activities in just a couple of visits. They need interventions, adaptations, assistive devices, and/or education and training to return to their daily routine.

Oftentimes, after an assessment, people have to wait weeks for a prior authorization which can delay our clients, patients, and students the right to access their best lives. In other cases, people will only have a couple visits approved and again have to wait weeks for continued treatment. This can cause extra pain, delays, or loss of skills needed to progress to the next level.

As a mom of a wonderful 12-year-old daughter who is funny, loves science, and music, who has a long medical history that impacts her daily living skills and who has an intellectual disability, I want AB 507 to get signed into law. When we started OT, we had to wait four weeks before getting authorization to see the OT after the assessment. We really needed help getting her to do more activities for her daily living. This was difficult as we had two younger children to take care of at the same time, one of whom was a baby. Had this been law, we could have implemented strategies right away to help her become more independent.

Instead, when we have to wait for her authorization to come back from insurance, she always loses skills that she needs to review before she can move on. Sometimes she is not able to go back to the skill. She has difficulty with her fine motor or coordination. For example, she was learning how to tie shoes with her occupational therapist and was so close to doing it on her own, when her visits ran out. It took almost four weeks to get the authorization for more OT visits. She completely lost the ability to tie her shoes and she regressed in other fine motor tasks. We had to start all over again with cutting her food and unfortunately had to put off shoe tying for a later goal. For her, four weeks is like six months. I want my daughter to be as independent as possible. Making us wait weeks before approving more visits makes it hard for her to continue to progress in many areas. Please consider supporting AB 507 to help our clients and their families be able to live more independent and best lives.

Thank you for your time and consideration,

Nicole Boyington, OTD, OTR
President, Wisconsin Occupational Therapy Association

# MEMO

DATE: November 8, 2023
TO: Assembly Committee on Health, Aging and Long-Term Care
FROM: Chris Reader, Executive Vice President
RE: Support of AB 541 to Increase Access to Mental Health Services

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Chairman Moses, committee members, thank you for allowing me the opportunity to speak in support of Assembly Bill (AB) 541 today. Wisconsin is facing a mental health crisis, something that has been acknowledged by the legislature and by the Governor when he announced 2023 as the "Year of Mental Health." Data from the National Institute of Mental Health shows that nationally, almost 23% of adults are living with mental health issues, and that increases to 49.5% for children between the ages of 13-18. At the same time, a 2019 Department of Health Services report estimates that 47% of adults with mental illness are unserved and demand is outpacing supply since the start of the pandemic.

AB 541 will increase the access and availability of mental health services for Wisconsinites at a time when they need it most. This legislation enables out-of-state providers to practice in Wisconsin via telehealth, without first needing to be licensed in Wisconsin. These providers would still be required to be licensed in the state from which they practice, have their license in good standing, and provide the patient with contact information for their credentialing authority in the case of needing to file a complaint. Simply put, this allows qualified providers, who are currently serving clients in their home state, to serve Wisconsinites as well.

This crisis is exacerbated by the fact there is a shortage of mental health providers in Wisconsin. In fact, recent data shows that we rank 32nd in the number of mental health providers practicing in Wisconsin. We have a shortage and the lack of providers only becomes more stark when we look at more rural areas of the state. Statewide, there is one provider for every 470 residents. However, in northern and western counties that ratio can climb as high as 13,030:1, like it is in Buffalo County. With this legislation, we can open up a greater supply of providers to the people that need it.

Furthermore, every year students come from around the country to attend one of Wisconsin's UW institutions. For many of the youth today, they are likely seeking help with depression or anxiety, and may have a relationship with a mental health provider in their home state. Under current law, these college students would need to go back to their home state to see their provider or find a new provider in Madison. AB 541 would remove regulatory burdens, allowing them to use telehealth technology to meet with their provider virtually.

The need to remove the burdens that unnecessarily restrict access to care has been recognized nationally. Currently, 26 states have some sort of exception for out-of-state telehealth providers. These

exceptions cover a number of medical and mental health provider groups, but often have a complex set of requirements. Wisconsin can do better, we know that providers from other states are not drastically different to the point that we need to impose duplicative licensure requirements or put up new bureaucratic barriers between providers and Wisconsinites that need help now.

There is no silver bullet for solving the mental health crisis in Wisconsin, but AB 541 will increase access to mental health services for Wisconsinites, and that warrants your support. I respectfully ask that you support AB 541.

Representative Moses and members of the committee,

Thank you for having me today to testify in favor of AB541, which would expand access to therapists in Wisconsin by allowing professionals who are deemed qualified to treat patients by other states to also treat patients in Wisconsin via telehealth.

According to the National Alliance on Mental Illness,[1] 75% of the people who will be diagnosed with a mental illness in their life begin to show signs by age 24. Last year, I became one of those people.

My name is Benjamin Garbedian. I'm a 22 year old college student from Waukesha, and last fall, I began having panic attacks. I've always kept a fairly busy schedule, and between school, work, social life, family life, and any other things that arise in a given day, stress caught up to me.

In an effort to try and stop my panic attacks, I began seeking out a therapist, and discovered how much of a shortage of mental health professionals there really is in Wisconsin. The vast majority of places and people I reached out to were booking out months on average, weeks if I was lucky. While I was able to eventually find help, many others in this state have not been as fortunate.

AB541 is simple. It would require the Department of Safety and Professional Services to recognize licenses for therapists that have been issued by other states to be valid to treat Wisconsinites. In the era of Zoom and other forms of telehealth, this is just common sense. There is no clinical difference between treating Illinoisians and treating Wisconsinites - there shouldn't be a legal difference either.

This reform is not only simple, it's actually been done here before. During the COVID pandemic, when we were facing a shortage of all healthcare professionals, the governor signed Executive Order 16, which allowed therapists from other states to be temporarily recognized as qualified here. That means that for the months that the emergency order was in place, there were therapists from states as close as Minnesota and as far away as Alaska who were able to treat patients via Zoom, who then were suddenly banned from seeing them again when the COVID orders ended. The National Institutes of Health reports that while the rates of Americans seeing primary care physicians via telehealth has fallen since COVID, rates of people seeking telehealth therapy have stayed high,[2] indicating a demand for reforms like this one.

Finally, 20 states[3] already have a program in place to recognize the licenses of other states, showing that this type of program works. Let's cut red tape and help give people like me the care we need. I urge you to vote in favor of AB541.

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[1]https://www.nami.org/mhstats
[2]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9412131/
[3]https://ij.org/legislative-advocacy/states-reforms-for-universal-recognition-of-occupational-licensing/

bellinhealth
Bellevue

Official Healthcare
Partner of the
Green Bay Packers

Representative Ron Tusler
Room 22 West
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Tusler:

My name is Dr. Rachael Vanden Langenberg and I am a board-certified primary care physician with Bellin Health, working in primary care/family medicine. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior Authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform prior authorization.

As a primary care clinician I value and rely on timely and unimpeded access to therapy services for my patients for a wide variety of conditions. Therapy is often one of the most effective and cost efficient treatment options available compared to more expensive, invasive, and/or higher risk diagnostic or treatment options.

When Prior Authorization limits or interrupts this care it can delay, extend, or even lead to negative outcomes for our patients. It also adds cost to the care as additional staffing or therapists time is require to complete the time consuming prior authorization process. The burdensome prior authorization adds to the overall cost of healthcare.

These reforms would allow patients to access physical therapy services included in their insurance policy without delays that slow or prevent patients from recovery and meeting their therapy goals. Please consider support for this important legislation.

Thank you,

DO
Dr. Rachael Vanden Langenberg, DO

3263 Eaton Road, Green Bay, WI 54311 Tel (920) 433-6700 Fax (920) 433-6719 www.bellin.org

Representative John Macco,
Room 208 North
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Macco:

My name is Dr. Ryan Berns. I am a board-certified family and sports medicine physician with Bellin Health. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes.

This legislation allows Wisconsin to join 30 other states who are taking the initiative to reform prior authorization.

As part of my practice, I treat a wide variety of orthopedic conditions and have extensive experience referring for rehabilitative and therapy services. Many of the orthopedic conditions I manage relies on those services, including physical and/or occupational therapy.

When Prior Authorization limits or interrupts this care it can delay, extend, or even lead to negative outcomes for our patients. It also adds cost to the care as additional staffing or therapists time is require to complete the time consuming prior authorization process. The burdensome requirements adds to the overall cost of healthcare.

For example I have personally had many patients tell me that they cannot get into physical therapy at all, have delays in starting PT or stop therapy all together due to issues with insurance coverage and out of pocket costs. This had led to significant delays in care and in some cases persistent pain and poor outcomes for patients.

These reforms would allow patients to access physical therapy services included in their insurance policy without delays that slow or prevent patients from recovery and meeting their therapy goals. Please consider support for this important legislation.

Thank you,

Dr. Ryan Berns, MD

Bellin Health
3263 Eaton Road
Green Bay, WI 54311

Representative John Macco
Room 208 North
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Macco:

My name is Dr. Sabeeha Bedi and I am a board-certified primary care physician with Bellin Health, working in primary care/family medicine. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior Authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform prior authorization.

As a primary care clinician I value and rely on timely and unimpeded access to therapy services for my patients for a wide variety of conditions. Therapy is often one of the most effective and cost efficient treatment options available compared to more expensive, invasive, and/or higher risk diagnostic or treatment options.

When Prior Authorization limits or interrupts this care it can delay, extend, or even lead to negative outcomes for our patients. It also adds cost to the care as additional staffing or therapists time is require to complete the time consuming prior authorization process. The burdensome prior authorization adds to the overall cost of healthcare.

These reforms would allow patients to access physical therapy services included in their insurance policy without delays that slow or prevent patients from recovery and meeting their therapy goals. Please consider support for this important legislation.

Thank you,

Sabeeha Bedi MD

Dr. Sabeeha Bedi, MD

bellinhealth | Titletown Sports Medicine & Orthopedics

Official Healthcare Provider of the Green Bay Packers

Representative Ron Tusler
Room 22 West
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Tusler:

My name is Dr. David Conrad and I am a board-certified orthopedic surgeon with Bellin Health. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes. With this legislation Wisconsin would join 30 other states who are taking the initiative to reform prior authorization.

SB-475 makes several key reforms, including:
"A surgeon's post-operative protocol require physical therapy for a certain period shall be a rebuttable presumption that the services in the post-op protocol are medically necessary. The health plan bears the burden of proving that the surgeon's protocol is not medically necessary."

This provision limits Prior Authorization for the post-operative patients we manage in our practice. Many of the orthopedic interventions we provide our patients rely heavily on specific rehabilitation including physical and/or occupational therapy protocols that ensure our patients have a positive, return to life outcome.

When Prior Authorization limits or interrupts this care it can delay, extend, or even lead to negative outcomes for our patients. It also adds cost to the care as additional staffing or therapists time is require to complete the time consuming prior authorization process. The additional cost adds to the overall cost of healthcare.

These reforms would allow patients to access physical therapy services included in their insurance policy without delays that slow or prevent patients from recovery and meeting their therapy goals. Please consider support for this important legislation.

Thank you,

Dr. David Conrad, MD

CONRAD MD

1970 S. Ridge Road, Green Bay, WI 54304 Tel 920.430.4888 Fax 920.430.4889 bellin.org

bellinhealth | Titletown Sports Medicine & Orthopedics

Official Healthcare Provider of the Green Bay Packers

Representative David Murphy
Room 318 North
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Murphy:

My name is Dr. Kenneth Kleist. I am a board-certified orthopedic surgeon with Bellin Health. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes. With this legislation Wisconsin would join 30 other states who are taking the initiative to reform prior authorization.

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Official Healthcare Provider of the Green Bay Packers

Representative Sortwell,
Room 214 North
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Sortwell:

My name is Dr. Steven Goldberg. I am a board-certified orthopedic hand surgeon with Bellin Health. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes. With this legislation Wisconsin would join 30 other states who are taking the initiative to reform prior authorization.

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bellinhealth | Titletown Sports Medicine & Orthopedics

Official Healthcare Provider of the Green Bay Packers

Representative Ron Tusler,
Room 22 West
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Tusler:

My name is Dr. Benjamin Ebben and I am a board-certified orthopedic surgeon with Bellin Health. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes. With this legislation Wisconsin would join 30 other states who are taking the initiative to reform prior authorization.

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Official Healthcare Provider of the Green Bay Packers

Representative Jeffery Mursau
Room 113 West
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Mursau:

My name is Krista Solarek and I am a physician assistant with Bellin Health, working in an sports medicine and orthopedic clinic. I help manage surgical and non-surgical orthopedic conditions. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes.
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Thank you,

Krista Solarek, PA-C

1970 S. Ridge Road, Green Bay, WI 54304 Tel 920.430.4888 Fax 920.430.4889 bellin.org

bellinhealth | Titletown Sports Medicine & Orthopedics

Official Healthcare Provider of the Green Bay Packers

Representative John Macco
Room 208 North
State Capitol
PO Box 8953
Madison, WI 53708

Dear Representative Macco:

My name is Dr. Kevin Shepet and I am a board-certified orthopedic surgeon with Bellin Health. I am also one of your constituents. I am reaching out regarding SB-475. The bill makes a number of meaningful reforms to the Prior Authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patients services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for Prior Authorization in our healthcare system, the emergence of third-party reviewers, known as Utilization Review/Utilization Management (URUM) companies, has made the process increasingly inefficient, adding healthcare expense, causing delays in care, and can lead to adverse patient outcomes. With this legislation Wisconsin would join 30 other states who are taking the initiative to reform prior authorization.

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Thank you,

Dr. Kevin Shepet, MD

1970 S. Ridge Road, Green Bay, WI 54304 Tel 920.430.4888 Fax 920.430.4889 bellin.org

Hello Representative Behnke,

My name is Seth Majerus and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform PA.

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These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Seth Majerus PT, DPT

Hello Representative Joy Goeben,

My name is Trisha Boldt and I am a physical therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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For example this past year I saw a 50 year old male who was coming to physical therapy for radicular neck symptoms. This was often aggravated by his work duties, we were just starting to reduce symptoms and make a change while working when we reached his visit limit of 8 physical therapy visits then was required to get authorization. It was required for me to call his insurance company and complete a peer to peer review prior to getting additional visits. I made the phone call, only to find out I needed to schedule that peer to peer review and they only operated 8-5pm, the same times that I'm already scheduled with patients. I was able to schedule a time 2 days later, extending his care even further. By the time I was authorized additional visits almost 2 weeks had passed in this man's care and he returned with another set back with his symptoms.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Trisha Boldt

Trisha Boldt, PT, DPT, GCS

Hello Representative Shae Sortwell,

My name is Jacquelyn McDonald and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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For example, I have had patients who have undergone traumatizing medical events such as a stroke. Their functional outcomes are highly dependent on early initiation of and consistency participation in rehabilitation. When a PA is necessary to initiate services or to continue services in the middle of their care, it means that they cannot receive the necessary rehabilitation, which is often working on skills such as getting in and out of bed, standing, and walking. Without physical therapy to address these skills, they are at an increased risk for falling or not regaining their independence in these skills.

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Thank you,

Jacquelyn McDonald, PT, DPT, NCS

Jacquelyn McDonald, DPT, NCS

Hello Representative Senator Ron Tusler,

My name is Luke Pan and I am a physical therapist with ThedaCare – Orthopedic, Spine, and Pain in Appleton, WI. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Luke Pan, PT, DPT

*Board-Certified Clinical Specialist in Orthopedic Physical Therapy (OCS)*

*ThedaCare - Orthopedic, Spine and Pain Center*

Hello Representative Mary Felzkowski and Jeffrey Mursau,

My name is Seugnet DeBauche and I am a PT with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

We know that rapid access to care can improve patient outcomes and this creates undue hardship for our therapists, myself included, to try to get authorization for services which ultimately will drive up the cost of care for patients, result in unnecessary imaging and possibly lead to increased surgical outcomes.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Seugnet DeBauche, PT, DPT, OCS, FAAOMPT
Physical Therapist, Team Leader, Bellin Health Sports Medicine and Orthopedics
Board Certified Clinical Specialist in Orthopedic Physical Therapy
Fellow of the American Academy of Orthopedic Manual Physical Therapists
Seugnet.DeBauche@bellin.org
Cell Phone: (414) 852-7488

Hello Representative Senator Andre Jacque,

My name is Luke Pan and I am a physical therapist with ThedaCare – Orthopedic, Spine, and Pain in Appleton, WI. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Luke Pan, PT, DPT

*Board-Certified Clinical Specialist in Orthopedic Physical Therapy (OCS)*

*ThedaCare - Orthopedic, Spine and Pain Center*

Hello Representative Jeffrey Mursau,

My name is Coral Thomson and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Coral Thomson

Coral Thomson, PT, DPT

Hello Representative Senator Robert Cowles

My name is Karlee Larson and I am a physical therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Karlee Larson, DPT

Karlee Larson, DPT

Hello Representative Jerry L. O'Connor,

My name is Jenna Lindsley and I am a PT with SSM Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Jenna Lindsley, DPT

Jenna Lindsley, DPT

Hello Representative Behnke

My name is Zachary Mestelle and I am a _Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Zachary Mestelle, PT, DPT, OCS

bellinhealth

Official Healthcare Provider of the Green Bay Packers

Hello Representative Peter Schmidt,

My name is Molly Huben and I am an Occupational Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform PA.

AB 507 makes several key reforms, including:

- Prohibit requiring PA for the first 12 physical therapy visits
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- Copays for PT shall be aligned with primary care copays
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This provision seeks to right size PA for the patients we manage in our practice.

When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you, Molly Huben, OT

Molly Huben, OT
Occupational Therapist
Bellin Team Leader Orthopedic Services
(office) 920-433-6754
Molly.huben@bellin.org

Hello Representative Kristina Shelton,

My name is Todd Winney and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Todd Winney, PT

Hello Representative Mike Gallagher,

My name is Jane Redlin and I am a Physical therapist assistant with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Jane Redlin, PTA

Jane Redlin, PTA

11/7/20203

Hello Representative Lee Snodgrass,

My name is Aaron Lautenschlager and I am an occupational therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Aaron Lautenschlager OTR/L, CHT

Hello Representative Joy Goeben,

My name is Dan Krueger and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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I have had multiple patients approved for only 2 visits after a surgery, prompting me to have to submit for more authorization before being able to see this patient without the risk of them being 100% responsible for the bill. Delaying care after a surgery is awful as there are very important interventions and goals that need be hit to be able to progress through a post-operative protocol. Not receiving this care can cause joints to stiffen, sensitize, and at times impact the long term outcome leading to chronic pain, limited range of motion, and disability.

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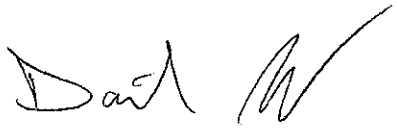
Thank you,

Daniel Krueger, DPT, OCS



Hello Representative Sortwell,

My name is Charlie DeCleene and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Charlie DeCleene, PT

Hello Representative Goeben,

My name is Dan Verhagen and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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For example, I have had a patient who opted to not attend physical therapy as they were unable to get approved number of visits. I do not know how this patient's situation ended. That is the frightening thing that this patient may go untreated for an extended amount of time until their problem escalates to the point where they are receiving more invasive and expensive care and/or insurance finally sees it is fitting for them to be seen in therapy.

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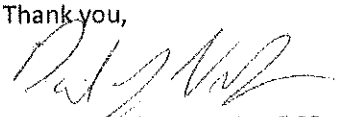
Thank you,



Daniel J Verhagen, DPT, OCS

Hello Representative Jeffrey Mursau,

My name is Coral Thomson and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Coral Thomson

Coral Thomson, PT, DPT

Hello Representative Behnke,

My name is Phil Schaible and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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As an example, I recently worked with an elderly female who was responding well to therapy and we were avoiding a surgical procedure. However, the authorization process after 7 visits required me to do a progress note every two visits and wait for a response delaying her care. I have to take the time to write the note, send it to the provider who has to read and approve it and then a staff member has to fax it in. This is all unnecessary cost that did nothing to improve her outcome. We can do better. Here at Bellin we measure our outcomes and average less than 7 visits per patient. The providers and I do not benefit in any way from the unnecessary burden of authorization and neither does the patient.

These reforms would allow patients to access the therapy services included in their insurance policy immediately that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Phil Schaible, DPT MS OCS FAAOMPT

Hello Representative John Macco,

My name is Eric Paulos and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Eric Paulos, PT, DPT

Hello Representative Shae Sortwell,

My name is Lisa Reinke and I am a PT with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Lisa M Reinke, PT, DPT, SCS

Hello Representative Andre Jacques

My name is Samuel Krier and I am a physical therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Samuel A Krier, PT

Hello Representative Shae Sortwell,

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Carrie A Stella, PT, DPT

Hello Representative David Steffen

My name is David Groop and I am a physical therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

David Groop P.T.

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Hello Representative Shae Sortwell,

My name is Anna Flottmeyer and I am a physical therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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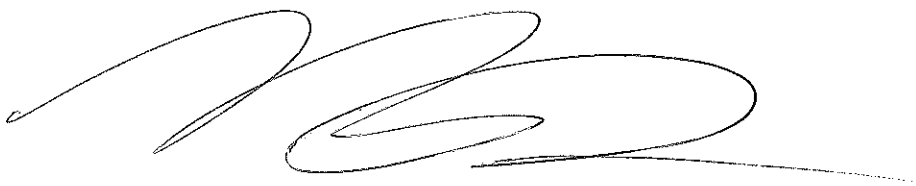
Many, many, many patients taking longer in therapy and prolonging their pain because we have to wait to take care of them. Along with it sacrificing relationship with our patients that we cant treat them until someone approves something and they have to sit in pain thinking it is because of us.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Malcolm Driessen, PT



Hello Representative Lori A. Palmeri,

My name is Michael Schumacher and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform PA.

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- Prohibit requiring PA for the first 12 physical therapy visits
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Thank you,

Michael Schumacher PT, DPT, OCS

Hello Representative John Macco

My name is Brandon Puser and I am a doctor of physical therapy with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Brandon M Puser, PT, DPT

Hello Representative Snodgrass,

My name is Tyler Burton and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

PT, DPT, CMTPT/DN

Tyler J Burton, PT, DPT, CMTPT/DN

Hello Representative Joe Kitchens,

My name is Chase Nier and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Chase Nier PT, DPT, SCS, CSCS

Chase Nier

Hello Representative Behkne,

My name is Marcus Boehm and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Marcus Boehm, PT, OCS

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PT, DPT, CMTPT/DN

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Hello Representative Joy L Goeben ,

My name is Jace Kaikuaana and I am a PT with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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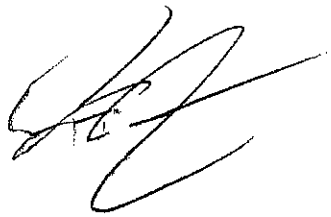
Jace Kaikuaana, PT



Hello Representative David Steffen,

My name is Anne Marie Van Den Elzen and I am a physical therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

PT, DPT

Anne Marie Van Den Elzen, PT, DPT

Hello Representative Elijah Behnke,

My name is Margaret Boerst and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Margaret Boerst, PT, DPT

Hello Representative Elijah Behnke,

My name is Thea Aguon and I am an Occupational Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Thea Aguon, OTR

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Hello Representative Elijah Behnke,

My name is Taylor Londo and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Taylor Londo PT, DPT

Taylor Londo, PT, DPT

Hello Representative Shelton,

My name is Shanie Williams and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Shanie Williams, MPT

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Hello Representative Sortwell,

My name is Jesse Krzyzanowski and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Jesse Krzyzanowski, DPT, SCS

Hello Representative David Murphy,

My name is Cooper Witt and I am a PT with ThedaCare. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Representative Schmidt,

My name is Casie Korth and I am a Physical Therapist (PT) with ThedaCare. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Casie Korth, PT, DPT

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Hello Representative Nate Gustafson,

My name is Melissa Schaefer and I am a Physical Therapist with ThedaCare. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

Melissa Schaefer, PT, DPT

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Hello Representative Murphy,

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PT, MPT, CMTPT

Stacey K. Grosnick, PT, MPT, CMTPT

Hello Representative Tusler,

My name is Dr. Zachary Koepke and I am a Physical Therapist with ThedaCare. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform PA.

AB 507 makes several key reforms, including:

- Prohibit requiring PA for the first 12 physical therapy visits
- Prohibit requiring PA in chronic pain cases for the first 90 days
- UR/UM companies shall not use claims data as evidence of outcomes to develop their approval policy
- Any denial or reduction of services must reference the applicable payer policy and include an explanation for the denial
- Copays for PT shall be aligned with primary care copays
- Providers shall be compensated for time spent entering information required for the UR/UM authorization

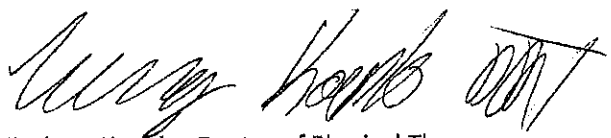
This provision seeks to right size PA for the patients we manage in our practice.

When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

Many patients will improve dramatically within the first few visits at physical therapy, however, if these visits are blocked from the PA system, we cannot help those patients. This leads to larger health care dollars spent on imaging, medications and possible hospital stays.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,



Zachary Koepke, Doctor of Physical Therapy

Hello Representative Sortwell,

My name is McKenna Larsen and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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Thank you,

McKenna Larsen, PT, DPT

Hello Representative Steffen,

My name is Alex Smithback and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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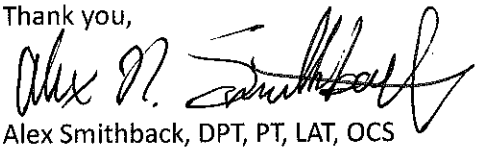

Alex Smithback, DPT, PT, LAT, OCS

Hello Representative Behnke,

My name is Melissa Leiterman and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Melissa Leiterman, PTA

Melissa Leiterman, PTA

Hello Representative David Steffen,

My name is Eric Erdmann and I am a Physical Therapist (PT) with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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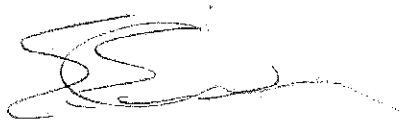

Eric Erdmann, PT, OCS, FAAOMPT
*Board-Certified Clinical Specialist in Orthopedic Physical Therapy (OCS)*
*Fellow of the American Academy of Orthopedic Manual Physical Therapists (FAAOMPT)*

Hello Representative Steffen,

My name is Daniel Roenz and I am a Physical Therapist with Bellin Health. I am also one of your constituents. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

For example, I recently had a patient who sustained a proximal humerus fracture (broke her shoulder) and subsequently had surgery. Her shoulder was immobilized before sent to physical therapy. Upon being referred to therapy, her insurance company approved 6 total visits before needing to request for reauthorization. We of course used those visits and requested more authorized visits. They then authorized 2 visits. We then requested more. They then sent to medical review which delayed the patient's care due to lack of coverage for 3 weeks. The administrative burden the prior authoraizations place on providers and patients is absurd. No medical professional would expect someone with a proximal humerus fracture to be effectively rehabilitate back to function so she can return to work as a UPS drive lifting heavy packages in 6 visits. When she was finally able to return to therapy, her shoulder had worsened! If her plan of care would have been approved as originally intended, it likely would have resulted in less total visits and less cost to the insurance company/patient! This is how insurance companies have been operating. There is no logic, no clinical decision making or input, just seemingly arbitrary rules that end up hurting patients and burden clinicians who end up leaving their workplace to work for cash pay, more wealthy patients who do not need insurance coverage. That is not the

healthcare system I want to work in. I hope that is not the healthcare system you want for your neighbors or family.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

PT, DPT, OCS

My name is Dr. Joe Kucksdorf. I am a doctor of physical therapy and the Team Leader of Clinical Quality and Professional Development for Bellin Health Sports Medicine and Orthopedics, in Green Bay, WI.

I have been practicing for 13 years. I am a board-certified orthopedic specialist, and fellowship trained in orthopedic manual physical therapy. A large part of my responsibility is helping guide the quality of care for the over 100 therapists at Bellin Health, providing care to the people of Northeast Wisconsin and Upper Peninsula of Michigan. A core philosophy of ours is providing our patients the highest **value** healthcare. To do so we must be able to provide not only the most effective care, but also the most **efficient** care possible.

One of the arguments we have heard third-party payers make, justifying the need for prior authorization, is without prior authorization in place, therapists will consistently over-use therapy visits. While those situations may occur, I assert they are rare, and our quality data opposes those statements. From 2010 through 2022 we tracked the number of visits from 74,235 individual patient episodes of care. The average number of visits for those encounters was 8 with a standard deviation of 6. That means the vast majority of episodes of care raged between 2 and 14 visits, a reasonable range for a wide variety of health conditions. I believe this to be the norm for the vast majority of therapy practices at Bellin Health and beyond.

For the last four years Bellin Health has offered its employees access to outpatient rehabilitative physical and occupational therapy services free of charge, covered 100% by Bellin Health. The free therapy, called Bellin First, does not have visit limit, co-pay, or prior authorization requirements. We tracked outcome data on Bellin First therapy benefits for 12 months, studying the effectiveness and efficiency of the care. During those 12 months we tracked 114 Bellin First episodes of care. The average number of visits per episode was less than 10. The data shows allowing patients and therapist's autonomy, free of burdensome prior authorization, that they have the ability to provide effective and efficient, high-value healthcare.

Another aspect of quality care we would like to point out is the use of validated health outcome measures. Outcome measures allow clinicians to assess a patient's response to care and routinely required by insurance companies in the prior authorization process. We do not have an issue with insurance companies asking for therapists to justify the number of visits or looking for the use of outcome measures as part of their care and/or documentation. What we do have an issue with is insurance companies making the process overly burdensome, dictating what type of health outcome measures we use, and when we use them. Therapists are educated and skilled in choosing the most appropriate outcome measures to employ with their patients. Prior authorization requiring specific measures or limiting the measures available increases burden on patients and therapists. They require therapists to measure outcomes for the purposes of insurance authorization only, which may or may not be appropriate for the specific patient's care needs. This translates into patients paying for prior authorization paperwork instead of the care they need.

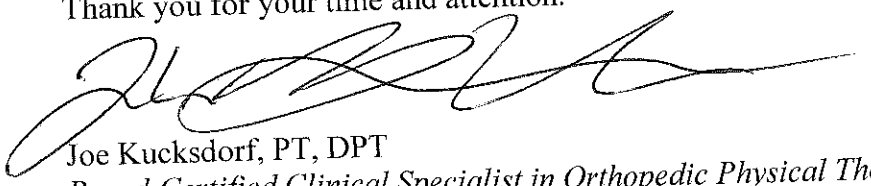
As a specific example, at Bellin Health, we choose to change to collecting Patient Reported Outcome Measurement Information System (PROMIS) family of outcome measures. We choose to move to the PROMIS measures over traditional 'legacy' measures because they

psychometrically sound, validated by research, adaptable to a wide variety of patients, and less burdensome (shorter) than traditional measures. We were driven to use the most effective and efficient outcome measures possible as part of our patient care and quality improvement work. However, we quickly found some of the large third-party payers did not recognize the PROMIS measures, leading to difficulty implementing the measures in the prior authorization process. It is frustrating and challenging when clinicians, who are best suited to choose the most relevant health outcome measures, are unable to use the measures they feel most appropriate to guide (and justify) care. It forces a clinician to adjust to meet the needs of payers over the needs of the patient.

Finally, at Bellin Health, we employ 6 individuals who are dedicated to physical and occupational insurance authorization work. A large majority of their work is managing prior authorization. While those 6 individuals are valued members of our healthcare team, their 6 salaries would be better suited providing value-added healthcare services elsewhere in the health system. Currently, their salaries contribute to increasing cost of care just to manage an ever growing and burdensome prior authorization processes.

As health care professionals, therapists pride ourselves on providing high value and ethical care, acutely aware of the high costs of healthcare. AB-507 makes important steps to limit the burdensome and low-value prior authorization process, increases the freedom for patients and clinicians to provide effective and effective healthcare.

Thank you for your time and attention.



Joe Kucksdorf, PT, DPT
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*Fellow of the American Academy of Orthopedic Manual Physical Therapists (FAAOMPT)*
Team Leader of Clinical Quality and Professional Development, Bellin Health Sports Medicine and Orthopedics, Green Bay, WI

UWHealth

Contact: Connie Schulze
Director, Government Affairs
104 King Street, Suite 303
Madison, WI 53703
608/516-2552 mobile
cschulze@uwhealth.org

Assembly Committee on Health, Aging and Long-Term Care
Testimony supporting AB507
Provided by Kristen Traino
Director of Ambulatory Operations - Outpatient Rehab Services, UW Health
November 8, 2023

Dear Chairman Moses and Members of the Committee:

Thank you for the opportunity to appear before you today to express support for Assembly Bill 507 (AB507). I am Kristen Traino, Director of Ambulatory Operations overseeing Outpatient Rehab Services for UW Health where my work intersects with patients seeking Rehab Services (physical and occupational therapy services, SLP and Orthotic and Prosthetic services) every day. In fact, in my 28 years as a practicing PT, 26 years have been with UW Health, 13 years as the Director of Rehabilitation. Over this time, I have seen the demand for Rehab services increase dramatically, and the burden on therapists to obtain prior authorization grow exponentially to adequately meet the patient need. Assembly Bill 507 would make accessing that care less burdensome and costly for patients and would greatly reduce the frustration experienced by providers seeking to serve patients quickly and efficiently.

Specifically, AB507 would make the following reforms:

- Prohibit requiring prior authorization for the first 12 physical and occupational therapy, SLP, other Rehab therapy visits.
- Prohibit requiring prior authorization in chronic pain cases for the first 90 days.
- UR/UM companies – 3rd party reviewers – shall not use claims data as evidence of outcomes to develop their approval policy.
- Any denial or reduction of services must reference the applicable payer policy and include an explanation for the denial.
- Copays for Rehab visits shall be aligned with primary care copays.
- Providers shall be compensated for time spent entering information required for the UR/UM authorization.

While we understand it is important to employ cost control measures in healthcare, the prior authorization process often has the opposite effect. For example, one in three physicians blamed prior authorization for a patient's serious adverse event, including hospitalization, permanent impairment, or death, according to a survey published by the American Medical Association (AMA) in March of this year. In addition, 86% of physicians surveyed said prior authorization rules led to greater use of healthcare resources overall, and 35% of physicians surveyed had staff whose sole job was managing prior authorization requests. Furthermore, the prior authorization process is often named as contributing to clinical workforce burnout as the process has gotten more burdensome in recent years.

In current state, delays waiting for prior authorization review and approvals result in delayed plans of care and

in some cases abandonment of treatment.
Short turnaround requests for prior authorization or repeated testing intervals by Utilization Management (UM) interrupt the therapy plan and are not reliable as a standard testing measure cycle.
Prior Authorization/repeated testing in a short time frame is likely not going to show enough neuromuscular progress and may delay authorization of the plan of care.
If UM has the goal of using repeated testing and claims data to make determinations regarding progress or meeting goals, this is not an evidence-based approach to care when done in a period of less than 12 weeks. Claims data alone is not an adequate way to assess progress. Billing codes on claims do not clearly paint a picture of a patient's progress toward their goals.

The changes to prior authorization proposed in AB507 will benefit therapy patients! Granting the first 12 rehab therapy visits without prior authorization will allow therapists and patients the **needed** visits to establish the plan of care, and make progress, or to meet their goals and potentially never need to engage prior authorization prior to discharge.
If the prior auth' request is within too short of a time frame or too few visits, it becomes very difficult to schedule visits and maximize the time between when prior authorization is required. Neuromuscular change, which is the goal in standardized testing is not expected in a short time frame of 2-4 weeks.

Passing AB507 can correct factors previously leading to denials of care for patients with expected improvement in therapy but were not given the time to show improvement. AB507 can correct delays in care waiting for prior authorization or premature denials, decreasing patient abandonment of care and chronicity of symptoms, improving outcomes, and ultimately leading to decreased costs to the system. Research has shown these patients who abandon care often continue to utilize emergency care, urgent care and advanced imaging.

At the end of the day, we all want what is best for patients and it is clear reforms around prior authorization are needed in order to achieve that goal. Our special thanks to the members of the committee who have already expressed support for AB507 including Rep. VanderMeer who is leading this legislation in the Assembly along with some of her fellow health committee members including representatives Brooks, Gundrum, and Magnafici who have signed on as co-sponsors. We hope you see fit to join them and will support AB507 with your "yes" vote.

Thank you for your consideration. I'd be happy to take questions at this time.

References:


1. https://www.medpagetoday.com/primarycare/generalprimarycare/103515
2. AMA prior authorization (PA) physician survey | AMA (ama-assn.org)

November 7, 2023

Dear Assembly Health Committee,

My name is Boyd Lumsden and I am a board-certified orthopedic surgeon with a subspeciality focus on surgery of the hand at the Hand to Shoulder Center of Wisconsin in Appleton. I am also one of your constituents. I am reaching out regarding bill AB-507, which is currently being circulated for co-sponsorship.

In our hand and upper practice, we see many patients requiring occupational and physical therapy for both post-operative and conservative conditions. It is my concern that the prior authorization process that many insurance companies have adopted over the past several years has limiting the therapy visits. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patient services, treatment, or equipment. If it is not approved, the insurance company will not pay for it, which leaves the provider or the patient left with the bill. While there is a role for prior authorization in our healthcare system, the emergence of third-party reviewers, known Utilization Review or Utilization Management companies, such as AIM (for Blue Cross and Blue Shield) and Evicore (for Network Health Plan), have made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

The bill AB-507 makes a number of meaningful reforms to the prior authorization process. When prior authorization limits or interrupts this care it can delay, extend or even lead to negative outcomes for our patients. This can occur with both post-operative patients as well as with conservative ones.

One example of a post-surgical patient Bradley G , a 26-year-old right-hand-dominant male who sustained an accidental flexor tendon and digital nerve laceration to his right dominant middle and ring fingers. On 7-6-23, he underwent a middle and ring finger flexor tendon repair with digital nerve repairs. His insurance company, Anthem used Carelon (formerly AIM) as the utilization review management company.

Occupational therapy was initiated on 7-12-22. Rehabilitation programs following flexor tendon repairs require very specific post-operative therapeutic interventions including use of a custom orthosis for protection, wound care, graded motion, edema control and gradual progression of the program requiring therapy at least 2 times per week. At the initial evaluation, the patient demonstrated a 70% impairment rating on the functional outcome measure used at our facility (Patient Specific Functional Scale) demonstrating deficits with dressing, showering, and performing child care tasks. The plan of care at the initial evaluation requested therapy authorization for 2 times per week for 12 weeks (24 visits).

- Carelon granted 11 visits initially, so the patient was instead seen 1 time per week versus the recommended 2 times per week.

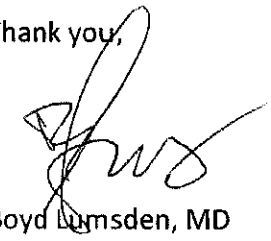
- At the reassessment on 9-11-23 (10.5 weeks post-op), the patient had improved functionally from a 70% impairment to 50%, but continued to be unable to make a full fist with his dominant hand making it difficulty to care for his 2-year-old daughter as well as manage utensils with cooking and meal preparation. The first several weeks of therapy are critical to insure optimal tendon gliding with skilled care to insure appropriate progressive loading of the repaired structures. At this stage of rehabilitation, the patient should have been able to perform a full fist and should be able perform most fine motor tasks involving with activities of daily living.

When submitting to Carelon, the provider is not alerted as to whether or not the authorization is approved. Instead, the provider has to continue to contact Carelon to check the status of the request, otherwise they will deny it and close the request. This places a significant burden on the provider with needing additional staff hours to follow up on these requests.

Since the initiation of the prior authorization process, it has become more burdensome for the provider and resulted in delayed care for patients which has, in some cases, significantly impacted my patients' outcomes.

Please consider supporting bill AB-507 to reform the prior authorization process. These reforms would allow patients to access occupational and physical therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals, which would provide better patient outcomes. Please consider supporting this important legislation.

Thank you,



Boyd Lumsden, MD

November 7, 2023

Dear Assembly Health Committee,

My name is Scott Olvey and I am an orthopedic surgeon with a subspeciality certification in surgery of the hand at the Hand to Shoulder Center of Wisconsin in Appleton. I am also one of your constituents. I am reaching out regarding AB-507, which is currently being circulated for co-sponsorship.

The bill makes a number of meaningful reforms to the prior authorization process in our healthcare system. Prior Authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patient services, treatment, or equipment. Otherwise, the insurance company will not pay for it – leaving the provider or the patient left with the bill. While there is a role for prior authorization in our healthcare system, the emergence of third-party reviewers – known Utilization Review/Utilization Management (URUM) companies, such as AIM and Evicore, have made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

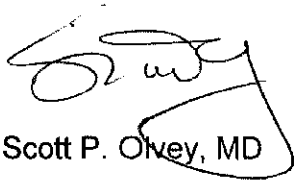
AB-507 makes the following key reforms, including "A surgeon's post-op protocol requiring physical therapy for a certain period shall be a rebuttable presumption that the services in the post-op protocol are medically necessary. The health plan bears the burden of proving that the surgeon's protocol is not medically necessary." Many of the orthopedic interventions we provide our patients rely heavily on specific rehabilitation including physical or occupational therapy protocols that ensure that our patients have a positive, return to life outcome. When prior authorization limits or interrupts this care it can delay, extend or even lead to negative outcomes for our patients.

Since the initiation of the prior authorization process, it has become more burdensome for the provider and resulted in delayed care for patients which has, in some cases, significantly impacted my patient's outcomes.

One example is a current patient of mine, Jim W. who underwent a rotator cuff repair on 5-8-23 due to a fall. He was allowed 15 visits of therapy initially, of which 10 were used. He ended up having complications which required an additional surgery to re-repair his rotator cuff on 8-30-23. When the request was made to Evicore (the UR for Network Health Plan), they allowed only 6 visits. With this type of procedure, patients are typically seen 2 times per week for at least 10-12 weeks. Allowing only 6 visits for this patient's recent surgery will require the therapist to perform more frequent reassessments, taking away from valuable treatment time. Often there is a delay is hearing back from the UR as to whether or not more visits will be authorized. This creates undue stress and frustration for the both the patient and therapist, as patients will often elect to cancel visits until they know that the visits will be covered by their insurance. This can result in increased stiffness prolonging the patient's recovery and limiting their ability to reach their functional goals.

These reforms would allow patients to access occupational and physical therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals, which would provide better patient outcomes. Please consider supporting this important legislation.

Thank you,



Scott P. Olvey, MD

November 7, 2023

Dear Assembly Health Committe,

My name is Shawn Hennigan and I am a board-certified orthopedic surgeon with a subspeciality focus on shoulder and elbow surgery at the Hand to Shoulder Center of Wisconsin in Appleton. I am also one of your constituents. I am reaching out regarding bill AB-507, which is currently being circulated for co-sponsorship.

I am writing to express my concerns regarding the prior authorization process that many insurance companies have adopted to limit the number of physical and occupational therapy visits are allowed for both conservative and post-operative care. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patient services, treatment, or equipment. If it is not approved, the insurance company will not pay for it, which leaves the provider or the patient left with the bill. While there is a role for prior authorization in our healthcare system, the emergence of third-party reviewers – known Utilization Review/Utilization Management (URUM) companies, such as Carelon/AIM and Evicore, have made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

The bill AB-507, makes a number of meaningful reforms to the prior authorization process, including "A surgeon's post-op protocol requiring (physical) therapy for a certain period shall be a rebuttable presumption that the services in the post-op protocol are medically necessary. The health plan bears the burden of proving that the surgeon's protocol is not medically necessary." Many of the orthopedic interventions we provide our patients rely heavily on specific rehabilitation including physical or occupational therapy protocols that ensure that our patients have a positive return-to-life outcome. When prior authorization limits or interrupts this care it can delay, extend or even lead to negative outcomes for our patients.

One example is a current patient of mine, David W. who is a self-employed 50-year-old farmer who underwent a complicated shoulder surgery involving a subscapularis reconstruction, latissimus dorsi transfer to the lesser tuberosity, rotator cuff repair, and bicep tenodesis on 9-15-22. His insurance company, Network Health Plan used Evicore as the utilization review.

Physical therapy was initiated on 10-20-22. Based on the patient's clinical presentation and complicated post-operative protocol, it was recommended the patient should be seen 2 times per week for 15 weeks (30 visits).

- Evicore granted 10 visits initially.
- A reassessment was performed on 11-25-23 and despite showing functional improvement in ability to perform dressing tasks involving pulling up his pants and applying his shirt, he continued with present with significant range of motion deficits (shoulder flexion to 56 degrees) leaving him unable to perform overhead reaching tasks. Physical therapy was recommended to continue 2 times per

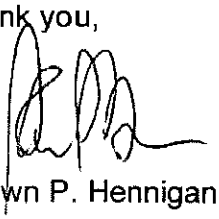
week. On the functional outcome measure (Patient Specific Functional Scale), the patient was still at a 70% impairment rating. Despite these deficits, Evicore only granted 8 visits.

- On 12-29-22, the patient was still making progress with being able to elevate his arm to 117 degrees, but was still having difficulty with reaching the top of his head and behind his back. On the functional outcome measure, the patient was now at a 50% impairment rating; however, his insurance only granted the patient 1 visit. Because of this, patient was unable to pay out of pocket for ongoing therapy despite his need to improve his range of motion and strength to perform the heavy work he needed to perform on the farm.

This is an excellent example of insurance companies driving care instead of healthcare professionals. Since the initiation of the prior authorization process, it has become more burdensome for the provider and resulted in delayed care for patients which has, in some cases, significantly impacted my patient's outcomes.

Please consider supporting bill AB-507 to reform the prior authorization process. These reforms would allow patients to access occupational and physical therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals, which would provide better patient outcomes. Please consider supporting this important legislation.

Thank you,



Shawn P. Hennigan, MD

To: Senator Rob Hutton

Wisconsin State Capital

PO BOX 7882

Madison, WI 53707-7882

From: Christina Dyess, PT

Manager of outpatient therapy services at ProHealth Care

725 American Avenue

Waukesha, WI, 53188

November 3, 2023

RE: Request for your Support of Bill AB507

Dear Senator Hutton,

I am a physical therapist, a health care administrator, and I am your constituent. I manage 14 outpatient therapy departments with ProHealth Care, Inc., the predominant health care system in your district. I have been a direct provider of health care or an administrator of it for the past 29 years in New Berlin, WI. I can assure you that the imposed Prior Authorization burden is a real issue and affects all areas of health care access for your constituents. Ultimately, the micromanagement by insurance companies increases health care costs for your constituents, and this is an issue that affects EVERYONE in your district.

Here is my very sincere and passionate request. I am writing to ask your support of Bill AB507. AB507 is important to ensure that patients receive the care that they need from Physical/Occupational Therapy without delays, interruptions, or fear of non-coverage.

As I am sure you are aware health care systems in your very district are struggling to maintain services and provide high quality care that District 5 constituents expect and deserve. One major contributing factor is the perpetual micromanaging that is required of our health care system to ensure coverage is approved for necessary care via the rigors of the imposed Prior Authorization processes. The insurance companies' micromanage the health care system, their patients, your constituents, with an ever increasing administrative burden to ensure coverage is approved.

This rigorous process creates many issues for our patients in the following ways:

1) *In order to obtain continuation of services, the insurance companies are implementing requirements for redundant and repetitive testing and assessments that waste valuable treatment time.* This is a waste of the patient's time and money. Limited treatment sessions are the result. This is hugely confusing and dissatisfying to patients and reduces the value of their care. It impedes, reduces, and delays recovery. It is wasteful of resources.

2*) Delayed scheduling of additional visits needed while the insurance companies are performing their reviews.* Gaps in care due to waiting for insurance authorization ultimately wastes health care dollars. Patients are less apt to complete their care when they have a gap in their appointment schedules due to waiting to hear back from the insurance companies on whether or not their services will be allowed to continue. This leads to undermanaged conditions that lead to chronic pain conditions. This ultimately costs the health care system and the patients more money to manage, as well as affecting loss of time from work due to pain and disability. As I am sure you are aware of Wisconsin's and the Nation's labor shortage, we cannot afford additional lost time from work in an environment where the labor pool is already stretched thin.

3) *The Prior Authorization processes imposed by the insurance companies ultimately creates delays along with fear and doubt for patients with the uncertainty of their care being covered.* This again leads to cancelling necessary care, and perpetuates the downward spiral outlined in point #2.

4) *Denying coverage for necessary services patients truly need to return to normal function and achieve maximum outcome for patient quality of life is jeopardized.* Oftentimes, the Prior Authorization process limits or reduces established protocols for rehabilitation, even post-operative conditions like total knee replacements. It defies logic to cover the costs of an astronomically expensive surgery, and then reduce or limit access to the necessary rehab to ensure the best possible outcomes and highest quality of life.

5*) The results of the Prior Authorization process affects my staff negatively. Morale is decreased when caregivers' hands are tied and unable to provide a complete course of therapy to achieve the best outcomes for their patients.* Helping others is inherently tied to the professional identities of physical and occupational therapists. When insurance companies delay or deny care, this ultimately affects patient satisfaction which then hurts staff satisfaction. The labor shortage in the United States has affected not only the physical therapy industry but also the healthcare industry as a whole. In 2021, about 22,032 physical therapists have left the workforce. If we cannot provide the care, we, as healthcare professionals feel is required, we feel undervalued and less than satisfied with our chosen profession. Our patients deserve access to necessary care, but there is the risk that care access could be reduced if the professionals are fleeing this field.

Lastly, as you are fully aware, health insurance premiums are ever-increasing and the insurance industry is less willing to cover the care our patients need. They have built-in barriers through Prior Authorization that need to be limited. My therapists provide extensive documentation already to the insurance companies on our patients' condition and the therapy plan. In these cases, more is truly not better, for anyone. Prior Authorization NEEDS to be limited to those situations where therapy services need to be extended beyond twelve visits, and it needs to be reasonably applied to allow therapists to do their jobs. This is more than a reasonable request from the struggling healthcare industry with these imposed requirements and restraints.

AB507 has several important parameters that will assist our patients, your constituents, to get the care they need without interruption.

Please consider supporting this very important bill.

Sincerely,

Christina J Dyess, PT

Manager of outpatient therapy services at ProHealth Care, Inc.

Home address:

12840 W Brentwood Dr.

New Berlin, WI 53151

Christina.dyess@phci.org

Wisconsin Legislators 11/5/23

Hello Assembly Health Committee. Thank you for taking the time to consider AB 507. My name is Dennis Kaster. I am the former president of the American Physical Therapy Association, Wisconsin. I have been a practicing 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. 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 that 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 workstations to put less stress on their bodies. We give them strategies to correct the problem, then manage it going forward. As it takes time to teach them what to do and do the correct exercises, 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 showing 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 nothing 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. Our 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 processes that vary greatly between each company that involve a great deal of administrative time to complete and submit. 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. I have 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 any SMART 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, which would decrease their costs in the long run and provide better patient outcomes. 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 forces increased costs for medical providers to process the paperwork required by the various authorization processes, without reimbursing the providers for this increased cost. 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. 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 Physical Therapy 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 507 as it is written. Please help us to decrease overall cost of care, improve outcomes and fight the opioid epidemic

Dennis Kaster, PT

Stevens Point WI

Hello Assembly Health Committee,

My name is David Nissenbaum MPT, MA, LAT, OCS, CIDN, TPI-2 and I am a Physical Therapist with Nissenbaum and Schleusner PRO Physical Therapy in the Madison area. I am reaching out regarding AB 507, which is currently being scheduled for an Assembly Health Committee hearing. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform PA.

AB 507 makes several key reforms, including:

- Prohibit requiring PA for the first 12 physical therapy visits
- Prohibit requiring PA in chronic pain cases for the first 90 days
- UR/UM companies shall not use claims data as evidence of outcomes to develop their approval policy
- Any denial or reduction of services must reference the applicable payer policy and include an explanation for the denial
- Copays for PT shall be aligned with primary care copays
- Providers shall be compensated for time spent entering information required for the UR/UM authorization

This provision seeks to right size PA for the patients we manage in our practice.

When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

For example, I recently had a patient who required prior authorization for Physical Therapy services after a total knee arthroplasty. Due to a delay in the pre-authorization process, our patient missed 2 full weeks of treatment. This caused a critical delay in care. They were unsure of what to do at home. When the patient was allowed to return to physical therapy the patients range of motion was stagnant, they were stiff, their gait was dysfuntional , quad was inactive and instead of progressing they were very far behind. We had to add visits during the week in order try and get the patient back up to speed. We were able to improve all the above dysfunctions, but that is not always the case. Too many patients are left untreated and can have permanent dysfunction from lack of timely treatment.

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

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

David M. Nissenbaum, MPT, LAT, PES, OCS

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

MARQUETTE UNIVERSITY

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**College of Health Science**
Marquette Physical Therapy Clinic
Cramer Hall 215
P O. Box 1881
Milwaukee, WI 53201-1881

P 414.288.1400
F 414.288.6079
W ptclinic@marquette.edu

November 5, 2023

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

RE: Assembly Bill 507

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 507. 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 507 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

*Personalized Care to Build a Better You*

Physical Therapy OF MILWAUKEE

Phone: 414-281-3444
Fax: 414-281-3435
www.yourptm.com
3906 S. 27th Street
Milwaukee, WI 53221

Nov 6, 2023

To Whom it May Concern:

When I opened Physical Therapy of Milwaukee 10 yrs ago, 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 also 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 insurance 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

PTM Physical Therapy OF MILWAUKEE

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

and at worst 1 month! We pride ourselves on being a full-service clinic providing a one-on-one patient care approach, and this type of service affects our brand reputation.

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 the bill AB507.

Dr. Sylvestra Ramirez
Doctor of Physical Therapy
Physical Therapy of Milwaukee, LLC
www.yourptm.com
p: 414-281-3444
f: 414-281-3435

Kyle Sampson
17495 W. Capitol Dr
Suite I
Brookfield, WI 53045

11/6/2023

Hello Representative Nancy Vandermeer,

My name is Kyle Sampson and I am a Physical Therapist with Freedom Physical Therapy in Brookfield, Wisconsin. I am also one of your constituents. I am reaching out regarding AB 507, which is scheduled for a hearing by the Assembly Health Committee on Wednesday, November 8. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform PA.

AB 507 makes several key reforms, including:

- Prohibit requiring PA for the first 12 physical therapy visits
- Prohibit requiring PA in chronic pain cases for the first 90 days
- UR/UM companies shall not use claims data as evidence of outcomes to develop their approval policy
- Any denial or reduction of services must reference the applicable payer policy and include an explanation for the denial
- Copays for PT shall be aligned with primary care copays
- Providers shall be compensated for time spent entering information required for the UR/UM authorization

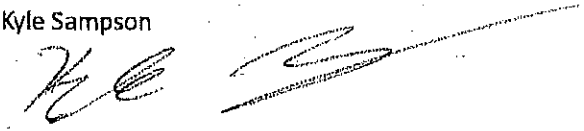
This provision seeks to right size PA for the patients we manage in our practice.

When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Kyle Sampson



November 6, 2023

Hello Assembly Health Committee Members,

My name is Trenton Rehman and I am a Physical Therapist with Freedom Physical Therapy Services in Brookfield Wisconsin. I am also one of your constituents. I am reaching out regarding AB 507, which is scheduled for a hearing by the Assembly Health Committee on Wednesday, November 8. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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This provision seeks to right size PA for the patients we manage in our practice. When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

For example, I recently had a patient who experienced two ACL tears (Initial and a Recurrent on the same limb) and her care was routinely interrupted by the processing of prior-authorization for more visits. When those visits finally came through, she was awarded very few. Not only was this frustrating, but it is my medical opinion that is has slowed her rate of progress and increased her need to for more care and more time on this rehabilitation. It has been quite clear that this few and far between visit approval approach is not ideal for her, or for any patient especially when dealing with a recent surgery that clearly requires more than a handful of visits and more time than a few weeks to fit those visits in and in the long run is costing everybody more time and money than if they would have just let us handle our plan of care the way we know works best.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Trenton Rehman, PT, DPT, OCS

C

**Cooley, Karen K**

to Sen.Wimberger@legis.wisconsin.gov, Rep.Macco@legis.wisconsin.gov, me, amy.reiter@wpta.or

I am writing to encourage your support of Bill # AB507 and SB475. Their 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 outpatient physical therapy visits authorized. Then it is not uncommon for insurance companies to take 1-3 weeks to respond. If unapproved, clinicians attempt peer-to[1]peer or medical review phone calls with the insurance company, that may involve canceling other patients' scheduled appointments to accommodate the time required. Disruption in therapy care plans are challenging from a scheduling standpoint, and they often result in prolonged and/or poorer functional patient outcomes.

Our therapy department has an authorization team that is assigned the exclusive task of obtaining authorization of therapy visits. They are frustrated by the insurance companies' delayed responses and how frequently they claim that they did not receive information sent. In particular, patients that have insurance managed by AIM or EVICORE are very challenging cases. 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 Bill # AB507 and SB475.

*Karen*

**Karen Cooley, PT, DPT**
Director of Outpatient Therapy, Eastern WI – Prevea Health
Ph: (920) 783-3115
Ext 73115

Dear Chairman Moses and Members of the Assembly Health Committee,

I am writing to encourage your support of Assembly Bill AB507 and SB475. 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 AB507 and SB475.

Respectfully,

Ashley Peterson, PT, DPT
Physical Therapist, Prevea/HSHS Green Bay, WI
Prevea Therapy Institute Shawano Ave. Site
1726 Shawano Ave. Green Bay, WI 54303
Ph:920.884.4852 or ext:64852
Ashley.Peterson@hshs.org

Dear Chairman Moses and Members of the Assembly Health Committee,

I am writing to encourage your support of Assembly Bill AB507 and SB475. 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 507 and SB475

Respectfully,

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

November 6, 2023

Dear Representative,

My name is Jennifer Glassbrenner, and I work in the insurance department at Optimum Therapies, LLC. I am also one of your constituents. I am reaching out regarding AB 507, which is scheduled for a hearing by the Assembly Health Committee on Wednesday, November 8. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services, leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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- Providers shall be compensated for time spent entering information required for the UR/UM authorization

This provision seeks to right size PA for the patients we manage in our practice.

When PA limits or interrupts the care we provide, it can delay, extend, or even lead to negative outcomes for our patients. There have been many instances over the years where I must process several authorization requests on one patient, submit all documentation which shows medical necessity, only to be denied. Patients do not all heal on the same timetable. This is not fair to our patients who only have a goal of getting better.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Jennifer Glassbrenner
Insurance/Authorization Dept.
Optimum Therapies, LLC

November 7, 2023

Dear Assembly Health Commitee,

My name is Nathan Van Zeeland and I am a board-certified Orthopedic surgeon with subspecialties both in hand and shoulder surgery at the Hand to Shoulder Center in Appleton. I am also one of your constituents. I am reaching out regarding AB-507, which is currently being circulated for co-sponsorship.

This bill makes a number of meaningful reforms to the prior authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patient services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for prior authorization in our healthcare system, the emergence of third-party reviewers, known Utilization Review/Utilization Management (URUM) companies, has made this process increasingly inefficient, causing delays in care and adverse patient outcomes. Examples of this include Carelon (formerly AIM) for Blue Cross Blue Shield and Evicore for Network Health Plan. AB-507 makes several key reforms, including: "A surgeon's post-op protocol requiring physical therapy for a certain period shall be a rebuttable presumption that the services in the post-op protocol are medically necessary. The health plan bears the burden of proving that the surgeon's protocol is not medically necessary."

This provision limits prior authorization for the post-operative patients we manage in our practice. Many of the orthopedic interventions we provide our patients rely heavily on specific rehabilitation including physical and /or occupational therapy protocols that ensure that our patients have a positive, return to life outcome.

Some of these surgeries are planned while others are due to emergent cases. When prior authorization limits or interrupts this care it can delay, extend or even lead to negative outcomes for our patients. Patients can often wait for long periods of time not knowing whether or not their therapy will be approved which causes even more stress and frustration to the patient who is trying to focus on their post-operative recovery.

These reforms would allow patients to access occupation and physical therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals, which would provide better patient outcomes. Please consider supporting this important legislation.

Thank you for time and consideration,

Nathan Van Zeeland, MD

November 7, 2023

Hello Assembly Health Committee,

My name is Joe Cullen and I am a board-certified Orthopedic surgeon with a subspecialty in hand surgery. I have been a hand and upper extremity surgeon in Green Bay and the Fox Valley for over 25 years. I am also one of your constituents. I am reaching out regarding AB-507, which is currently being circulated for co-sponsorship.

This bill makes a number of meaningful reforms to the prior authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patient services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for prior authorization in our healthcare system, the emergence of third-party reviewers, known Utilization Review/Utilization Management (URUM) companies, has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

AB-507 makes several key reforms, including:

- "A surgeon's post-op protocol requiring physical therapy for a certain period shall be a rebuttable presumption that the services in the post-op protocol are medically necessary. The health plan bears the burden of proving that the surgeon's protocol is not medically necessary."

This provision limits prior authorization for the post-operative patients we manage in our practice. Many of the orthopedic interventions we provide our patients rely heavily on specific rehabilitation including physical and /or occupational therapy protocols that ensure that our patients have a positive, return to life outcome.

Some of these surgeries are planned while others are due to emergent cases. When prior authorization limits or interrupts this care it can delay, extend or even lead to negative outcomes for our patients. Patients can often wait weeks not knowing whether or not their therapy will be approved which causes even more stress and frustration to the patient who is trying to focus on their post-operative recovery.

These reforms would allow patients to access occupation and physical therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals, which would provide better patient outcomes. Please consider supporting this important legislation.

Thank you for time and consideration,

Joseph Cullen, MD

November 7, 2023

Assembly Health Committee:
Re: Regarding AB 507

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

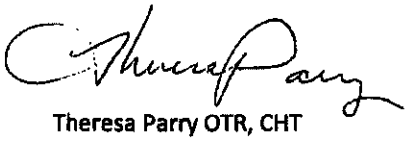
November 7, 2023

Assembly Health Committee
re: Regarding AB 507

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

11-7-23

Dear Assembly Health Committee,

I am writing to share with you my deep concern about the way the prior authorization process dictates how many visits a patient may get. In my practice, which includes over 20 therapists, this is a weekly issue. Patients who have had serious surgeries are being authorized as few as 5 visits. In a situation like, this, the patient who will need to be seen 2 times per week will need a progress note completed within 2 ½ weeks. The prior authorization groups are looking for functional improvements and goal achievement. During the acute stages of a post operative procedure such as a rotator cuff repair, we are not anticipating any significant functional improvements. These documentation demands only add to the cost of health care, by taking away valuable patient care from therapists, demanding additional time from therapy coders, transcription and authorization departments.

There is no logical reason that a progress report and request for additional visits should be required within such a short time frame. Bone and tissue healing have a specific time frame (around 6-12 weeks), this is not something that we can impact, however, we can provide the necessary rehabilitation during the acute stages to ensure that these patients outcomes are optimal. This includes but is not limited to edema control, wound care management, range of motion as indicated by surgeon, fabrication and adjustment of custom orthosis, patient education and advancement of a home exercise program.

We request that the Assembly of Health puts a stop to the prior authorization groups from creating an arduous process that ultimately takes away from patient care, increases health costs by addressing bill AB 507.

Sincerely,

Vivienne F. Neerdaels, OTR,CHT, COMT, CLT

November 7, 2023

Dear Assembly Health Committee,

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, PT, CHT
Physical Therapist
Certified Hand Therapist

November 7, 2023

Dear Assembly Health Commitee,

My name is Jon Cherney and I am an board-certified Orthopedic surgeon with a subspecialty in hand surgery. I have been a hand and upper extremity surgeon in the Fox Valley for over 20 years. I am also one of your constituents. I am reaching out regarding AB-507, which is currently being circulated for co-sponsorship.

This bill makes a number of meaningful reforms to the prior authorization process in our healthcare system. Prior authorization is a process in which healthcare providers must obtain approval from the insurance company before providing patient services, treatment, or equipment. Otherwise, the insurance company will not pay for it, leaving the provider or the patient left with the bill. While there is a role for prior authorization in our healthcare system, the emergence of third-party reviewers, known Utilization Review/Utilization Management (URUM) companies, has made this process increasingly inefficient, causing delays in care and adverse patient outcomes. AB-507 makes several key reforms, including: "A surgeon's post-op protocol requiring physical therapy for a certain period shall be a rebuttable presumption that the services in the post-op protocol are medically necessary. The health plan bears the burden of proving that the surgeon's protocol is not medically necessary."

This provision limits prior authorization for the post-operative patients we manage in our practice. Many of the orthopedic interventions we provide our patients rely heavily on specific rehabilitation including physical and /or occupational therapy protocols that ensure that our patients have a positive, return to life outcome.

Some of these surgeries are planned while others are due to emergent cases. When prior authorization limits or interrupts this care it can delay, extend or even lead to negative outcomes for our patients. Patients can often wait for long periods of time not knowing whether or not their therapy will be approved which causes even more stress and frustration to the patient who is trying to focus on their post-operative recovery.

These reforms would allow patients to access occupation and physical therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals, which would provide better patient outcomes. Please consider supporting this important legislation.

Thank you for time and consideration,

Jon J Cherney, MD

November 7, 2023

Honorable Members of the Wisconsin Assembly Committee on Health,

My name is Kip Schick, and I am a physical therapist, and I've worked for UW Health in Madison for more than 21 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.

I ask for your support of Assembly Bill 507.

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, which results in a physical therapist justifying 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 such as rehabilitating patients following joint replacement surgery or shoulder 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, which 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 although often with fewer visits than requested. 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. 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.

In closing, I respectfully ask for your support of Assembly Bill 507. Thank you.

Regards,

Kip Schick

Kip Schick
42 South Owen Drive
Madison, WI 53705

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

Jacob Brenner, DPT
Devin Mattson, DPT, ATC
Brett Roberts, DPT

November 3, 2023

Devin Mattson, Doctor of Physical Therapy
Roberts Physical Therapy – Plainfield
**AB 507**

Chair, Representative Clint Moses and the Assembly Health Committee:

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 507.** 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.

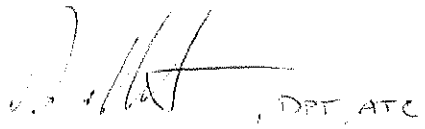
Insurance providers for medical services have increased the usage of third-party payors to determine prior authorizations and approved visits for care utilizing an algorithm-based approach. This approach is overseen by the primary medical insurance but is flawed in one specific fundamental way which is timeliness. To give an example of this flaw, we 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 507 as this change is needed to foster improved care, without unnecessary delay, to our community and its constituents.**

Sincerely,



Devin Mattson, PT, DPT, ATC

TO: Chairman Moses and Members of the Assembly Health Committee
FROM: Kate Lewis
DATE: November 8, 2023
RE: Support of Assembly Bill 507

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-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 aftereffects 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 received went far above and beyond what was likely the suggested protocol as none of the medical professionals involved in my care 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 $5,665. 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 20211 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 accepting 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 507.

Katherine E Lewis
1734 N Hi Mount Blvd
Milwaukee, WI 53208

November 7, 2023

Dear Representative Murphy,

HELLO AGAIN! As a practicing Physical Therapist (PT), a RECENTLY RETIRED small business owner, a former member of the Physical Therapy Examining Board and a consumer of health care I encourage your support of AB507.

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/PATIENTS by choosing to work with their third party payers. Unfortunately, the commercial health insurance industry has metastasized to the point where it 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 AGAIN to an 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. HOW CAN WE BEST PUSH BACK AGAINST THIS CLEAR AND PRESENT DANGER?

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. TAKING SOME TYPE OF RELEVANT ACTION LIKE supporting AB507 is a necessary step in regaining consumer freedom, supporting small businesses and limiting the harm caused by misguided third party payer policies. THANK YOU DAVE!

Sincerely,

Mark Shropshire PT

Hello Representative Plumber,

My name is Taylor Podboy and I am a Physical Therapist Assistant with New Life Physical Therapy. I am also one of your constituents. I am reaching out regarding AB 507, which is scheduled for a hearing by the Assembly Health Committee on Wednesday, November 8. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

With this legislation Wisconsin would join 30 other states who are taking the initiative to reform PA.

AB 507 makes several key reforms, including:

- Prohibit requiring PA for the first 12 physical therapy visits
- Prohibit requiring PA in chronic pain cases for the first 90 days
- UR/UM companies shall not use claims data as evidence of outcomes to develop their approval policy
- Any denial or reduction of services must reference the applicable payer policy and include an explanation for the denial
- Copays for PT shall be aligned with primary care copays
- Providers shall be compensated for time spent entering information required for the UR/UM authorization

This provision seeks to right size PA for the patients we manage in our practice.

When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

For example, many patients that have been impacted by this are often left to be independent when they need skilled physical therapy the most and can cause a massive decline in their progress. Post-operative care also is impacted by this as they typically require more than the prior authorization provides due to the extent of their diagnosis.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Taylor Podboy, PTA

11/6/2023

Hello Representative Plumber,

My name is Kyle Herbert and I am a Physical Therapist Assistant with New Life Physical Therapy. I am also one of your constituents. I am reaching out regarding AB 507, which is scheduled for a hearing by the Assembly Health Committee on Wednesday, November 8. I am seeking your support of our bill. AB 507 makes several meaningful reforms to the prior authorization (PA) process in our healthcare system. PA is a process in which healthcare providers must obtain approval from insurance companies before providing patient services, treatment, or equipment. If PA is not obtained, the insurance company will not pay for our services – leaving the provider or the patient left with the bill. While there is a role for PA in our healthcare system, the emergence of third-party PA reviewers – known as Utilization Review/Utilization Management (UR/UM) companies – has made this process increasingly inefficient, causing delays in care and adverse patient outcomes.

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This provision seeks to right size PA for the patients we manage in our practice.

When PA limits or interrupts the care we provide it can delay, extend, or even lead to negative outcomes for our patients.

For example, having a patient that has a low back injury and must wait to be seen by a physical therapy provider I have had patients perform "self care" including looking on social media or quick searches online for exercises to help with their low back pain. Unfortunately, when someone performs self-diagnosis it can lead to perform exercises or receiving advice that is inappropriate for their specific issue they have and can delay or even make symptoms worse.

These reforms would allow patients to access the therapy services included in their insurance policy without delays that slow or prevent them from accomplishing their therapy goals. Please support this important legislation and help us provide the patients of Wisconsin with better healthcare outcomes.

Thank you,

Kyle Herbert, PTA

Physical Therapy
& Rehab Specialists
Clear Lake • Turtle Lake
Amery • Prairie Farm

**Memorandum**
**Date:** 11/07/2023
**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 AB507.**

To whom it may concern:

We are a private practice physical therapy clinic in rural northwestern Wisconsin with 4 locations. Over the last few years, we have been dealing with increasing authorization components with insurance companies. We have 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.

Carelon, formerly AIM, is one of the most stringent 3rd part administrators that we see the biggest limitations and hoops with authorization. As billing administrator's, we see very limited number of visits being authorized along with poor cross over to the payer. We spend many hours on the phone troubleshooting denials for no authorizations not being on file and learning that the system is not working well with on another. One company blaming the other company, no one wanting to take ownership of the issue, all the while, reimbursement is held up and more follow up is required by the billing team. Appeals are filed and some are upheld, when all along we have everything in place. As clinician's, we change how we document just to appease the 3rd party administrator. We look at how we write progress notes and goals to reflect exactly what they are looking for to maximize visit potential ending with a clinical review to receive 2 visits. There is extra time 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 are not treating patients, we are not financially successful.

We experience this with other 3rd part administrators as well such as Evicore. This in no consistency with the algorithm of how the visits are calculated. We recently had an Evicore authorization (for Security Health Plan) who was a post operative total knee in January 2023. We saw this gentleman for his condition. He returned in September 2023 with an IT band issue on the same leg and after a limited number of visits, Evicore denied any more physical therapy even though, in our professional opinion and training, felt he met medical necessity. We feel this is a tremendous fail of the system.

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 profession. Something needs to change and we support Bill AB507.

Sincerely,

*Becky Melton*

Becky Melton, Administrator

*Emily Monson*

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
www.clearlakept.net
930 Elden Avenue, Amery, WI 54001
p. 715-268-5103 • f. 715-268-5101
224 River Avenue S, Prairie Farm, WI 54762
p. 715-455-4103 • f. 715-455-4106