



1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

December 8, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIO-9986-NC
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subject: Federal External Review Process – Request for Information

Dear Sir/Madam:

On behalf of the American Physical Therapy Association's (APTA) 78,000 member physical therapists, physical therapists assistants and students of physical therapy, I am pleased to share our comments on the Federal External Review Process under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act). We support HHS' goal to ensure that external reviews by independent review boards (IROs) in the relevant geographic areas are ultimately conducted by IROs that have expertise in both the health insurance and health provider industries. The IRO protocols must be developed with adherence to federal laws, including, but not limited to, constitutional due process rights.

Section 1001 of the Affordable Care Act, Public Law 111-148, Section 2719(b)(1) of the Public Health Service Act (the PHS Act), provides that the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) are authorized to establish an external review process for group health plans and health insurance if a State has not established an external review process that, at a minimum, provides the consumer protections set forth in the National Association of Insurance Commissioners' (NAIC) Uniform External Review Model Act (the Model Act).

Patients with certain conditions can greatly benefit from receiving timely care from physical therapists. By receiving immediate medical care, an individual's ability to function independently and quality of life is greatly improved. In addition, increased costs to the health care system can be avoided by ensuring timely care. Physical therapists and physical therapist assistants have a significant interest in ensuring that individual's benefits are not needlessly denied due to faulty decision support development.

In the development, maintenance and updating of decision support protocols, it is important

to ensure that IROs do not over-standardize protocols resulting in routine benefit denials to the detriment of the quality of care to the patient. The following areas should be given adequate consideration in protocol development:

Definitions

APTA supports the Model Act's Definitions Section. Definition of terms should be consistent among plans and policies and should be defined as presented in the Model Act. For example, a "health care professional" is defined as "a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with State law." This definition ensures that the appropriate health care professional will review the evidence and provide the best professional judgment regarding the decision. For example, in cases where rehabilitative or physical therapy benefits are in question, the health care professional reviewer should be a physical therapist. As a result, the health benefit decision will be made based on the best practices for that specific treatment.

"Medical necessity" or "medically necessary" are terms which should be given careful consideration if used as decision criteria. Currently, there is inconsistency among insurers' definitions of these terms. Protocols developed based on an insurer's flawed definitions would result in benefit denials and patient's medical conditions could worsen causing additional health care expense and possible costly litigation for all parties involved. Insurers should consider the views of experts in the profession regarding whether services are medically necessary and should not deny claims for physical therapy and other services based on information presumptions or "rules of thumb." In fact, in a well-known case, the practice by fiscal intermediaries of routinely denying Medicare claims for skilled therapy based on "rules of thumb" was found to be a violation of a beneficiary's due process rights. *Fox v. Bowen*, 656 F. Supp. 1236 (D.Conn. 1986).

Stabilization of a medical condition is another concept subject to confusion in the insurance community. Stabilization does not equate to cessation of treatment in all cases. Often, a continued type of treatment improves, then maintains a patient's stable condition and withdrawal of the treatment results in further deterioration of the patient's health, function or mobility. Therefore, stabilization should not be incorporated into a plan of care as basis of denial in a standardized protocol package. The criteria used by the insurer to cease treatment after a patient has been stabilized should be expressly communicated to the beneficiary. This disclosure allows the individual to make fully informed decisions regarding his medical treatment and health plan choice.

Transparency of Insurers' Processes

Claims should be processed quickly, within a limited time period. Insurers should provide full and detailed explanations of the rationale for their denial of their claim. If documents are missing, the beneficiary should be fully informed and provided time to submit the documents. Insurers protocols for claims processing and denials should be transparent so that the consumer fully understands what is necessary and can be proactive in providing the information that is required to access and receive the health benefit. This transparency will enable the consumer to be proactive, thereby decreasing the likelihood of a denial and a

lengthy review process.

Adequate Notice

Insurers should provide a written notice to the claimant of his or her external review rights and a detailed explanation as to why the claim was denied during the internal review process. Additionally, a claimant should have ample time to appeal after receipt of a denial. If the claim is urgent, the beneficiary should receive written notice of his or her options for an expedited review and be fully informed of any deviations, including, but not limited to, timeline variations, between the internal and external review processes.

External Reviews should be *de novo*

If the internal plan decision is contested by the claimant and submitted for external review, all external reviews should be *de novo* as implied by Section 2718 of the Affordable Care Act in the language which allows enrollees to present new evidence. This is a significant consumer protection as it allows individuals to fully exercise their appeal rights.

IRO Should have State Regulatory Expert Designee

IROs should have designees who are experts in State and local regulations so that the decision support protocols are in compliance with all State and local laws and updated accordingly. In this Notice, the Departments may enter into one or more contractual relationships with an IRO. Therefore, if an IRO is responsible for a multi-state area, then this designee should be an expert in each State in which the IRO operates.

In conclusion, we thank you for the opportunity to voice APTA's concerns regarding IROs involvement in the external review of health plan denials. If you need any additional information, please contact Deborah Crandall at 703-706-3177 or deborahcrandall@apta.org. Thank you.

Sincerely,



R. Scott Ward, PT, PhD
President

RSW:dc