Utilization Management, Internal Appeals and External Review

Talking Points for PPS Members

* Utilization Management is becoming the “go to” tool for insurers to limit medically necessary services, but denials prior to reaching UM are commonplace.
	+ The Kaiser Family Foundation published data from 2021 for plans that reported rates of denials for insurance plans listed within the Exchange/Marketplace, with some notable bad actors. In particular, KFF finds:
	+ Denial rates by issuers varied widely, ranging from ranging from 2% to 49% (from 1% to 57% in 2019) of in-network claims. Of the 230 major medical issuers in HealthCare.gov states that reported for the 2021 plan year, 162 reported receiving at least 1,000 in-network claims and show data on claims received and denied. Together these issuers reported 291.6 million in-network claims received, of which 48.3 million were denied, for an average in-network claims denial rate of 16.6%. In 2021, 41 of the 162 reporting issuers had a denial rate of less than 10%, 65 issuers denied between 10% and 19% of in-network claims, 39 issuers denied 20-29%, and 17 issuers denied 30% or more of in-network claims. Issuers that report denying one-third or more of all in-network claims in 2021 included Meridian Health Plan of Michigan, Absolute Total Care in South Carolina, Celtic Insurance in 7 states (FL, IL, IN, MO, NH, TN, TX), Ambetter Insurance in 3 states (GA, MS, NC), Optimum Choice in Virginia, Buckeye Community Health Plan in Ohio, Health Net of Arizona, and UnitedHealthcare of Arizona. <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/>
	+ As noted, these denial rates occur *prior to reaching UM*. Access to medically necessary care is being severely restricted by high denial rates and UM proliferation.
* Private practice PTs have reported significant issues with utilization management and other claims denials. In a survey fielded January 26, 2021, PPS physical therapists reported:
	+ Children with developmental delays, cerebral palsy or down syndrome having **treatment stopped commonly for two weeks at a time** because they use the 4 visits in less than two weeks and another plan of care must be approved before treatment can start again.
	+ They are not giving many visits, it’s very frustrating when a **post op patient comes in and we only get 5 visits to start out with and then maybe a few more, and then they request clinical information after the second time we go for PA**. This interrupts the patient care because they don’t want to be seen without approval
	+ **Phone wait times increasing by ~50% since the change was implemented.**
	+ **Limiting units as well as visits even though the insurance company itself has no cap on either.**
	+ **Randomly denying claims for no [UM company] authorization when [UM company] has no jurisdiction over the patient’s plan.** When we receive the denials, we check [the] website then call [payer] customer service to send the claims back for reprocessing. [Payer] reps then give a series of other excuses as to why the [UM] authorization is required, or how the patient already used their physical therapy benefits early this year, etc.
	+ **Phone wait times to confirm benefits of more than 5 hours.**
* Private practice PTs can do something about utilization management and claims denials, and two strategies that may be helpful are contained in your patients’ right to internal appeals and external reviews.
* What is an internal appeal?
	+ “[Internal appeal:](https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/) If your claim is denied or your health insurance coverage canceled, you have the right to an internal appeal. You may ask your insurance company to conduct a full and fair review of its decision. If the case is urgent, your insurance company must speed up this process.”
	+ <https://www.healthcare.gov/appeal-insurance-company-decision/>
* What is an external review?
	+ “[External review:](https://www.healthcare.gov/appeal-insurance-company-decision/external-review/) You have the right to take your appeal to an independent third party for review. This is called external review. External review means that the insurance company no longer gets the final say over whether to pay a claim.”
	+ <https://www.healthcare.gov/appeal-insurance-company-decision/>
* PPS urges physical therapy practices to support their patients by educating themselves and their patients and helping patients use their rights to access medically necessary services by appealing treatment or UM denials.