APTA Michigan
A Chapter of the American Physical Therapy Association

August 18, 2020

Dear Dr. Keshishian,

The American Physical Therapy Association Michigan Chapter (APTA Michigan, formerly Michigan Physical Therapy Association) appreciates the opportunity to meet with BCBSM to continue our discussion regarding the ways in which the physical therapy community and BCBSM can collaborate to improve access and quality and reduce costs of physical therapy care for your members.

Regarding telehealth, APTA Michigan greatly appreciates BCBSM's recognition of the importance of telehealth during the COVID-19 pandemic. We are hopeful that BCBSM also recognizes the value of permanent adoption of telehealth beyond the public health emergency, and we therefore respectfully request that payment for telehealth for physical therapy continue to be a covered service.

Regarding the eviCore utilization management program, APTA Michigan remains concerned about denial of medically necessary care and the substantial administrative burden imposed by prior authorization processes. The eviCore program substantially adds to the cost of healthcare delivery by providers and to costs of BCBSM benefits administration. Although we appreciate the intent behind the revised initial authorization process for Category B and C providers, significant concerns still exist and have been reported by providers in other states (OR, WA, AK) who have had experience with this revision:

- The extended authorization period is not helpful and does not reduce provider administrative burden if the number of visits is not increased because providers still have to continue to request the additional visits. Although a greater number of visits is advertised as part of the revision, according to other states it appears that this is not occurring with any consistency. .
- The communication given to patients by eviCore does not clearly explain that the provider can request additional visits. Many patients see the low number of authorized visits over an extended duration and discontinue therapy assuming they cannot have more care. To counter this, providers are having to spend additional time explaining the program and process to patients, adding to administrative burden.
- The risk adjustment process does not seem to be accurately accounting for complexity as providers see little difference in the number of authorized visits despite widely varying clinical presentations. As an example, a similar number of visits are being authorized for a complicated post-operative case as for a low complexity overuse injury.

APTA Michigan would like to know if there are other utilization management program paradigms being explored by BCBSM, including outlier management-based approaches, incentive programs, etc. In particular, we note that BCBSM is adopting Turning Point Healthcare Solutions for some service lines, and we are curious if there are plans to use that organization for rehabilitation management. As discussed in previous meetings, APTA Michigan would like the opportunity to provide input on any significant pending changes ***prior to*** BCBSM consideration and/or adoption of an alternative utilization management program. This will

help to reduce provider abrasion and avoid many of the ongoing implementation and execution issues experienced with eviCore.

Regarding our ongoing discussion about value-based care, we would like to continue to explore alternate payment policies with BCBSM that facilitate a shift toward value-based payment. We previously communicated on the following suggestions outlined below:

- Incentivize systematic outcomes data collection and reporting - this could be through subsidizing fees for participation in accredited clinical registries, exempting providers who use registries or other systematic outcomes measurement and reporting process from corePath, or providing incentive payments based on performance on standardized outcome measures.

- Use a claims or visit threshold after which corePath would be required. If no clinical outcome measures were used to provide the basis for a request for continued care (or no extenuating circumstances were articulated), no further care would be authorized.

- Reconsider how the categorization process is linked to utilization management. Do not use corePath with Category A and B providers. To capture Category A providers who have low utilization but deliver poor quality care, screen Category A providers thru claims data to identify the frequency of patients starting care with another provider within 30 days as a proxy for low visits but poor quality care, and then subject those providers to corePath as well.

- Identify a sample of outliers using a claim or visit threshold on a routine basis to initiate further inquiry. Providers who cannot provide evidence of clinical outcome measurement and/or confounding factors that demonstrate their unique patient population to justify their aberrant utilization should then be subject to corePath. Although this is similar to what is currently done with C providers prior to consideration of disaffiliation, initiating this contact sooner with a collaborative approach in the spirit of changing practice, rather than under threat of disaffiliation, would help move providers toward developing the necessary culture to effectively participate in a value-based payment environment.

    - APTA Michigan supports exploration of outlier-based utilization management programs, however, we also recognize that execution of key elements is critical. These include the risk-adjustment process used to determine the outlier threshold(s), whether the program is provider or payer funded, and if provider funded, whether payment increases will be made to offset these costs, etc.

- Regarding direct access (i.e. revising the physician prescription requirement to be consistent with Michigan state law which only requires a physician prescription for treatment after 10 visits or 21 days), APTA Michigan continues to encourage BCBSM/BCN to consider the extensive data previously provided regarding both the reduced physical therapy-related costs and total costs (due to reductions in unnecessary physician visits, medication, and imaging) that are associated with direct access episodes of physical therapy compared with physician-referred episodes of care.

- APTA Michigan would also like to express several concerns related to the MQIC Guideline on the Management of Low Back Pain recently adopted by BCBSM/BCN:
    - Most concerning is the statement that 90% of episodes of acute LBP resolve within 6 weeks and the subsequent, implicit recommendation to wait for 2 weeks before referral to physical therapy. It is unfortunate that the myth of self-limiting episodes of back with low recurrence rates continues to be propagated:
        - This faulty assertion was first made by Dillane et al[1] who conducted a record review of a single general practice where the duration was measured as the number of weeks from the first to the last consultation with the general practitioner. The assumption was that the final physician consultation represented the resolution of symptoms.
        - Croft et al[2] debunked this assumption: "Although 90% of patients ceased to consult with their general practitioner concerning their symptoms after three months, most still had substantial low back pain and related disability" and in fact only 25% of patients had fully recovered from their low back pain in one year.
        - The persisting nature of low back pain symptoms was incidentally noted in a meta-analysis by Artus et al[3] that demonstrated that patient enrolled in RCTs are similar to those seen in general practice.

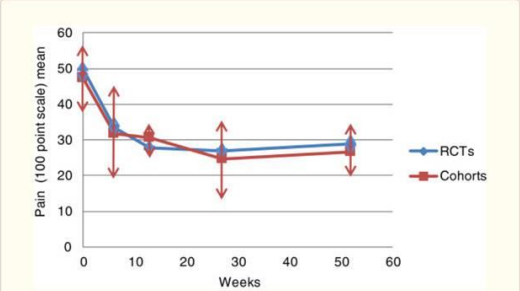

Figure 3

Pooled mean pain intensity scores (95% confidence interval) for the included RCTs and observational cohort studies from baseline to 52 week follow up.

        - Further, the MQIC Guideline fails to make comprehensive recommendations for early identification of those at greatest risk for development of recurrent and chronic pain: "Prognostic factors for development of recurrent pain include (1) history of previous episodes, (2) excessive spine mobility, and (3) excessive mobility in other joints. Prognostic factors for development of chronic pain include (1) presence of symptoms below the knee, (2) psychological distress or depression, (3) fear of pain, movement, and reinjury or low expectations of recovery, (4) pain of high intensity, and (5) a passive coping style."[4]
    - The MQIC Guideline is also not comprehensive in consideration of already established guidelines related to the rehabilitation management of LBP. In particular, it does not include Level A evidence for the use of directional preference in the management of low back pain.[4]
    - In addition to direct access and clinical pathways encouraging early access to physical therapy for low back pain, some payers, including UHC and TRICARE, are eliminating some patient cost sharing.[5,6]

Thank you for your consideration of these comments. We look forward to our upcoming meeting and ongoing discussions.

Sincerely,

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President
APTA Michigan

[1]Dillane J. Fry J, Kalton G. Acute back syndrome-A study from general practice. BMJ. 1966. 2: 82-84.

[2]Croft P, Macfarlane G, Papageorgiou A, Thomas E, Silman A. Outcome of low back pain in general practice: a prospective study. BMJ. 1998. Vol. 316:1356-59.

[3]Artus M, van der Windt D, Jordan KP, Croft PR. The clinical course of low back pain: a meta-analysis comparing outcomes in randomised clinical trials (RCTs) and observational studies. BMC Musculoskelet Disord. 2014;15:68.

[4]Delitto A, George SZ, Van Dillen L, et al. Clinical Practice Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopaedic Section of the American Physical Therapy Association. J Orthop Sports Phys Ther. 2012;42(4):A1-A57.

[5]https://www.apta.org/news/2020/06/30/tricare-lbp-demonstration?_zs=UF3fV1&_zl=lWIx6

[6]https://newsroom.uhc.com/news-releases/back-pain-program.html