October 15, 2018

Vycki Rupakus, PT, MS, DPT
Director, Therapy Provider Engagement
eviCore Healthcare
1610 Arden Way, Suite 280
Sacramento, CA 95815

Dear Vycki-

Thank you again for your invitation to provide input into additional complexities that would require a greater intensity and/or number of visits.

The MPTA conducted a focused survey of three large outpatient practices (private practice, rehab agency, tertiary care hospital system) in addition to 20 additional physical therapists across the state who have recently communicated with MPTA about eviCore. Survey questions were all open-ended and organized by body region:

> ***For each of the major joints (cervical, shoulder, elbow, spine, hip, knee, ankle), please think of the typical complex case that walks through your door and you just know they will take more intensity/time/visits to get better and reach their goals. What are those 1 or 2 key characteristics/complexities that help you to know that?***

Response rate was good and there was good alignment of responses during thematic analysis. Many of the items recommended below were commonly identified by 15-50% of respondents, despite the responses only being open-ended.

Please also note that feedback was also frequently received about the undisclosed thresholds used by eviCore for identifying baseline severity of functional impairment/compleixty using the various functional measures. The MPTA requests that these be transparent and that they may need to be adjusted (i.e. patients who the clinicians believe to have severe involvement do not appear to be categorized as such by eviCore). Additionally, the adjustment in allowed intensity for other characteristics such the post-surgical shoulder with severe limitation in ROM may also need to be adjusted.

As a starting point for discussion, the MPTA suggests the following complexities be considered for inclusion in prior authorization applications:

General complexities that affect intensity/duration/intensity of care across body regions:

- Truly constant pain
- Period of immobilization >4 weeks
- Chronicity of pain >6 months
- Age > 80 (yes/no)

- Frequent falls (>1 fall in the past 6 months)
- Morbid obesity (BMI >35)
- Severe disruption of sleep (<4 hours per night or waking 3 or more times per night)
- Significant anxiety/depression (yes/no)
- High fear avoidance beliefs (FABQw >34, FABQpa >15)
- History of prior surgery (yes/no)
- Secondary regional conditions (e.g. shoulder pain accompanied by thoracic dysfunction; elbow pain with secondary shoulder pain and/or dysfunction, knee pain with associated hip or ankle/foot dysfunction, etc) (yes/no)
- Current smoker

Cervical Region

- Frank radiculopathy with sensory and/or motor deficit (yes/no)
- History of previous cervical surgery (yes/no)

Shoulder

- Severe limitation in shoulder ROM (<90 deg flexion/abduction). As previously noted, the current visit/intensity adjustment for post-surgical status allowed by eviCore may need to be modified.

Elbow

- Repetitive elbow movements at work/unable to work (yes/no)

Spine

- Repetitive spinal movements at work/unable to work (yes/no)
- Frank radiculopathy with sensory and/or motor deficit (yes/no)

Hip

- Labral tear (yes/no)
- Severe limitation in hip ROM (<90 deg flexion, 20 deg abduction, <20 deg internal rotation, or <30 external rotation)

Knee

- No additional suggestions beyond the general complexities, though the visit/intensity adjustment allowed by eviCore for loss of knee extension ROM >10 deg may need to be modified.

Ankle

- WB restrictions/unable to tolerate WB (yes/no)
- Add the Foot and Ankle Ability Measure as a measure of function related to foot/ankle dysfunction.

It also important to note that although efforts to better capture complexity for automatic authorization is appreciated, the MPTA has significant reservations about increasing the length and burden of the prior authorization request/process. Therefore, we continue to encourage consideration of our previous suggestions, especially suggestions #2 and 3 which we believe to be feasible near-term solutions:

1. Incentivize systematic outcomes data collection and reporting - this could be through subsidizing fees for registries (FOTO, APTA Outcomes Registry, WebOutcomes), exempting providers who use registries or other systematic outcomes measurement and reporting process from corePath, or providing incentive payments based on performance on outcome measures.

2. 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.

3. Reconsider the categorization process. 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.

4. Identify a sample of outliers using a claims 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.

Sincerely,

Michael J. Shoemaker, PT, DPT, PhD
President
Michigan Physical Therapy Association

Cc: BCBSM Provider Relations