For this first round of analysis, how was the $1,250 threshold determined and what was the percentage and number of practices categorized as outliers? What percentage and number of those outliers were determined to be sufficiently unique and were removed from outlier status? Are hospital and other facility-based practice data included in this threshold?

• First, the $1250 is not a threshold restricting patient care. Instead, it is a clinical benchmark that initiates a detailed medical record review when exceeded during our January or July reporting period. The clinical benchmark is an average *of allowed dollars per patient* for the previous 12-month period for Blue Cross Blue Shield of Michigan (BCBSM) commercial claims.

SecureCare developed the clinical benchmark based on our extensive knowledge of typical physical therapy utilization patterns. The BCBSM physical therapy fee schedule was applied to these utilization patterns to arrive at the clinical benchmark, which was approved by BCBSM. Approximately 20% of clinics are currently categorized as outliers. The clinical review process will determine if a clinic is classified as a specialty clinic and thus held to a different standard. Additionally, outpatient hospitals and facilities are held to a similar standard.

For those practices on a corrective action plan, a new average is calculated based on the full six-months? Is compliance based solely on billed amounts or also based on documentation/chart audit? Are there other auditing procedures, authorizations, or other interaction with practices during the six-month period?

• Our report card data utilizes a 12-month rolling average using allowed paid claims data. After an education or corrective action plan is implemented, the data moving forward for the next 6-9 months will include both old and new data. In addition, we will monitor trends of key performance metrics to ensure progress is being made. This may consist of a follow-up targeted review using post-education data.

Transparency and provider inclusion in your auditing process was a key element we had discussed previously. When will APTA MI and/or provider representatives be a part of the auditing process?

• We will schedule quarterly meetings with APTA-MI representatives to help you further understand and discuss our processes and allow time for questions and input.

Regarding specific concerns raised by our members, most concerning was the tone of the corrective action plan letters which was threatening and overemphasized disaffiliation. APTA Michigan understood the SecureCare approach to be one that (at least initially) was focused on mentoring and facilitating a change in practice patterns.

• Our initial focus is on clinics with the network's highest utilization patterns. We focus on a mentoring and educational approach with clinics but provide a summary of our review findings, current clinic metrics, and the action required. We also provide a detailed review with screenshot examples to illustrate the clinics' deficiencies that need attention. However, the

egregious and unwarranted patterns of treatment were quite evident in the initial group of clinics under review. Unfortunately, some clinics' interactions and tone before requesting medical records came across as unwilling to listen, understand our clinical review program, and comply. For clinics to understand and correct their behavior expeditiously, straightforward, and transparent language is necessary.

The same threshold and methodology should be applied equally across practice types for similar patient types (e.g., same billed amount for hospitals and private practices for musculoskeletal-based practices).

• Our expectation is that regardless of the setting, utilization of physical therapy services should be appropriate.

Different thresholds should be established for non-musculoskeletal-based practices, especially pediatric and neurorehabilitation practices.

• We agree with this concept. However, currently, it is difficult to identify specialty practices easily. Therefore, at the outset, we require all clinics above the benchmark to undergo reviews. This will help us identify those clinics that won't be held to our current benchmark, and sometime in the future, develop a benchmark for those identified as specialty clinics.

For patients with multiple episodes of care in a year, the cost for each episode should be used in calculating the average billed amount, not the total billed amount for the year for that patient (e.g., billed amounts for a knee pain-related episode of care should not be combined with billed amounts for a low back pain episode of care).

• SecureCare looks at the average allowed dollars per patient over a 12-month period. Based on detailed claims analysis, clinics have similar percentages of patients with multiple episodes of care. Therefore, this information was already included in our benchmarking analysis and will not be reported separately. However, we understand that multiple care episodes require more medically necessary care for a given patient.

Please note that BCBSM billing and coding policy uses the mid-point rule and not the total time/eight-minute rule. This would, for example, allow four distinct procedures in 32 minutes and could be appropriate with supporting documentation.

• Yes, we are aware of the BCBSM payment policy regarding timed codes. However, the use of multiple units or multiple CPT codes would still need to meet medical necessity guidelines.

Notification of outlier status in the corrective action plan letter should include an invitation for the clinic to provide data supporting the reasons why they are an outlier (e.g., case mix of elderly, medically complex, pediatrics, neuro, etc., or evidence of good outcomes based on outcome registry metrics). Although we understand that the SecureCare program is based on billed amount and cannot systematically consider clinical outcomes, those clinics that

participate in outcome registries and who demonstrate average or better outcomes should be exempt or given a different/more liberal threshold.

• Our medical record request letter currently offers clinics the opportunity to identify any unique aspect of their practice that may elevate their statistics. The final determination of specialty clinic status resides with SecureCare based on several factors, including case complexity, date of birth, diagnosis, etc. Our clinical review does objectively consider clinical outcomes. Our clinical review process looks at proper documentation, correct coding, and patient management. More peer-to-peer research is needed to validate the accuracy of outcome registries and databases, the different variabilities associated with clinics participating, and measurement methodologies.