**Memorandum**

**To:** Interested Parties

**From:** Robert Hall, JD, MPAff

PPS Senior Consultant

**Date:** 10/30/2023

**Re:**  PPS Survey Highlights

The Private Practice Section of the American Physical Therapy Association includes 4,000 physical therapist members focused on the business of physical therapy. PPS has received repeated reports of frustration with Anthem’s implementation of a new utilization review structure known as AIM Specialty Health (AIM). Anthem has implemented AIM in many states, but Anthem operates in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. The complaints we have fielded apply to group health insurance plans that should in most cases not be considered “grandfathered,” and therefore subject to a number of consumer protections embedded in the Affordable Care Act.

Anecdotally, Anthem does not have a positive reputation among PPS members. High denial rates are part of the problem, and there is evidence to support the assertion that Anthem plans do a worse job than other insurers at paying for covered services. The Kaiser Family Foundation published data from 2019 for plans that reported their rates of denials for those listed within the Exchange/Marketplace. In particular, KFF finds:

Denial rates by issuers varied widely, ranging from 1% to 57% of in-network claims. Overall for 2019, 34 of the 122 reporting Healthcare.gov major medical issuers had a denial rate for in-network claims of less than 10%. Another 45 reporting issuers denied 10%-20% of in-network claims that year, 32 issuers denied 20%-30%, and 11 issuers denied more than 30% of in-network claims (Figure 2). Issuers that report denying one-third or more of all in-network claims were Blue Cross Blue Shield (BCBS) of Tennessee (57%), **Anthem BCBS of Georgia (40.5%), Anthem BCBS of Maine (40.4%), Anthem BCBS of Ohio, (39.5%), Anthem BCBS of Virginia, (36.2%), Anthem BCBS of New Hampshire, (35.2%), and Anthem BCBS of Kentucky (33.3%)**.

<https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/>

These denial rates do not reflect the impact of the proliferation of AIM, but add to the access problem that policies and practices at Anthem plans create for patients seeking the benefits of the low-cost, high-touch care physical therapists provide.

PPS Survey

We received responses to a survey of PPS membership fielded January 26. The survey asked two questions in regards to our members’ interaction with Anthem and its new utilization review product.

The questions were:

1) Are the following codes being denied for payment retroactively by AIM in your practice? Codes listed for denial in their new policy include:

• 97014 Estim, unattended

• 97012 Mechanical traction

• 96004 Gait analysis, instrumented

• 96004 Motion analysis, instrumented

• 97033 Iontophoresis

• 97016 Vasopneumatic compression

2) Are you being required to spend time on the phone with AIM or Anthem to confirm coverage and/or payment for medically necessary services? If so, please let us know specifics of your practice’s time on the phone.

Some of the highlights of responses to question 2 follow:

* 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.**
* We have a 14-year-old on service and Anthem’s rep tried to tell me she **used all 24 visits of her physical therapy benefit between P.T., O.T. and chiropractic services in a two-week timeslot in January**. I called the patient’s mother and asked if this sounded right. The patient’s mother then called Anthem. Anthem pulled all of our claims and are now processing them for payment, but there was a lot of time and effort we shouldn’t have had to expend.
* Not having their system updated with the NCCI edits that were withdrawn 01/01/2021 by CMS.
* **[Patient] was in an MVA – had 3 body parts, Neck, Thoracic, Low Back …they only gave us 4 visits to start** – I put in the request for additional visits and scanned in all 4 of his notes along with the request for review….they denied more than 4 visits for the following explanation: Non-Authorized / Criteria Not Met … Now my next step is to call them and ask for the peer to peer review…which I dread because I will have to sit on hold & when they finally answer. Then I have to hope that the treating therapist is available to drop what she is doing and pick up the phone…this patient did come on Wednesday to his appt although we did not have auth’n & paid for the visit himself.
* **Limiting units as well as visits even though the insurance company itself has no cap on either.**
* **Anthem randomly denying claims for no AIM authorization when AIM has no jurisdiction over the patient’s plan.** When we receive the denials, we check AIM’s website then call Anthem customer service to send the claims back for reprocessing. Anthem’s reps then give a series of other excuses as to why the AIM 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.**
* Challenges scheduling peer-to-peer reviews.
* Lack of clarity regarding whether Anthem requires AIM prior authorization.
* Availity mismatches with AIM.
* On multiple occasions, therapists have tried to call AIM to do clinical/peer to peer reviews and have spent 30 minutes to an hour on hold waiting for someone to pick, but have been unsuccessful each time.
* AIM closed one of our rehab request cases on MLK day, however we were unsuccessful at getting through to them that day to discuss because their offices were conveniently closed that same day.
* Approval of only 5 visits at a time and maxing out with 8 to 10 visits.
* Untimed codes automatically triggering reviews (which are delayed and are retroactively denied).
* Submitted for authorization on 2/3, then called to check on the status of the auth on 2/11, told that it hadn't even been reviewed yet, but was set to close on 2/12.
* Code 97014 being denied retroactively.
* The inability to use more than one diagnosis code if/when there is more than one, or if there are co-morbidities that affect the primary diagnosis and the potential response to treatment.
* My biggest pet peeve with calling them besides the hold times, is the confirmation of all of our data and then the request for all of the doctor’s address, phone number, and fax number, every time we call or get online. Even if it is an extension of the PT and not a first request.
* We have also noted that the number of sessions approved is very low. They give 2 or 4 sessions and then expect progress in the reports. We all know that for some diagnoses things are slower and take time.
* We have had one denial that we appealed the way we were instructed, only to be told that appeals have to go directly to Anthem.
* Any time I need to get a retro-auth from AIM, it is a nightmare. I've been told by AIM that I can sub a retro auth as long as I have the claim # from the original DOS. I have had success with a couple of these, but mostly I get a message stating that I need to contact BCBS. I currently have about 4-6 patients who I am trying to get payment on. These are from when AIM was first being utilized, and the date to submit auth was pushed back a couple times in Oct / Nov. 2019. I have contacted AIM and was instructed to write a letter to Anthem asking for them to cover. I have done this once already with no response.
* Our biggest issue with Anthem is finding out whether or not auth is needed. It's not always clear when we look up their benefits on Availity, and getting a rep on the phone is near impossible. I have spent up to 40 min. on hold or being transferred around with Anthem. 40 minutes is my time limit that I've given myself for one phone call. I usually get disconnected, or have to hang up to help a patient. I don't have a problem getting the auth, but if anything could be done to help identify if an auth is required, that would be most helpful, in my opinion.
* I don’t deal with AIM until it’s time to request the authorization. I have only had a few that have gone through the portal easily…right now I have 2 that are sitting as “open” status pending authorization for the past few days & may need to cancel upcoming appointments (for tomorrow afternoon) if they don’t respond.
* …in regard to denials from our Commercial Anthem plans. There seems to be confusion among the programs related to when authorization is required vs when clinical practice guidelines are implemented. While we understand that the AIM clinical practice guidelines are being accepted/adopted by the Anthem plans, we are also seeing inappropriate denials for “no auth” in our commercial contracts that do not require authorization through AIM.
* The average wait time on hold is approximately 45 minutes. Verification of benefits can be done on the AIM portal however when calling for Peer to Peer review and other requests wait times are quite long.
* If you complete the paperwork online, but get to the end and you are requesting particular codes, they make you call anyway to get authorization.
* Verifying benefits with BCBS has also become very time consuming. We have had several calls that the hold time was over 60 minutes and every call is over 30 minutes. One call recently was an hour and a half and we hung up before the call was ever answered. No one has this kind of time.
* On hold for 4 hours, then transferred and on hold for 4 hours and the call was then disconnected. Another time was a 3-hour hold, transferred for another 1.5 hour hold and when the call was answered, there was nobody on the line.
* 5 hours/week on the phone with Anthem/AIM.