***Template: Letter to the Office of the Insurance Commissioner***

Dear Commissioner **[NAME]**:

We are a physical therapy practice in **[STATE]**. The purpose of this letter is to provide a detailed overview of the adverse patient impacts resulting from **[PAYER]**’s decision to contract with **[UM VENDOR]** to manage its physical therapy benefit. Through our experience and patient surveys, we have found that the **[UM VENDOR]** program is not consistent with industry peer review policies and definition of medical necessity. Furthermore, our attempts to collaborate with **[PAYER]** and **[UM VENDOR]** have proven unsuccessful.

Attached are the findings from **[NAME OF YOUR SURVEY]**, a survey that objectively demonstrates the significant consumer impact of the **[UM VENDOR]** program.

Highlights of the survey include:

*SAMPLE TEXT ONLY—CUSTOMIZE BASED ON YOUR SURVEY RESULTS:*

•It has taken 15 minutes or more in **[X number]** of UM review cases to complete required paperwork to submit an authorization for initial and subsequent visits. For therapists and the patients they treat, this administrative burden translates into lost time for direct patient care.

•The vendor requires prior authorization after **[X number of]** visits. Plan of care disruptions via small these incremental visit approvals have become ubiquitous. When authorization requests are approved in this manner, clinically appropriate treatment is disrupted. This is compounded by the need for submission of repeated treatment requests and authorization of visits. Interruption of services interferes with patient progress and increases the likelihood of higher downstream costs. It is important to note that while in actuality **[UM VENDOR]** denies a portion of the requested visits through prior authorization, the communication to the provider and patient indicates an approval of services. Because of this “approval,” neither the patient nor the therapist is afforded the right to appeal the failure to approve all the visits requested..

•**[X number]** of our requests were denied without a rationale for the adverse determination. As the therapist was not given a rationale for the denial, it is reasonable to assume the health plan enrollee did not receive a documented rationale either. In the absence of a rationale, submission of an appeal by either the patient or the provider is impeded. Additionally, most state insurance laws and regulations require the consumer to be informed of the reason for the denial. It is also unclear what information is being shared with **[PAYER]**’s enrollees regarding its relationship with **[UM VENDOR]** and the vendor’s impact on the contracted rehabilitation benefit.

•We waited one week or more for a response to requests for approval of therapy services in on **[X number of occasions]**. This is extremely concerning as the reported incidents are not isolated but rather represent a repeated pattern within our state and medically necessary skilled rehabilitation is unduly delayed. This results in pain for the patient and concerns about their ability to secure coverage for the benefits cited in **[PAYER]**’s medical policy. Furthermore, the patient is unwilling to attend physical therapy until the approval is in hand as they do not want to be liable for further out of pocket costs. [Numerous studies](https://academic.oup.com/ptj/article/94/1/14/2735361) demonstrate delaying approval for skilled physical therapy will not only increase the physical therapy cost for that episode, but will also result in higher downstream costs. More important, **[UM VENDOR]** is jeopardizing and negatively impacting the patient’s recovery and ability to function. This is particularly problematic for post-operative cases where such delays could have serious effects including the need for additional surgical intervention, a potentially costly and devastating scenario for the **[PAYER]**’s enrollee.

•In **[X number of cases]** the **[UM VENDOR]** medical necessity review process did not coincide with the diagnosis/severity of the patient and/or known clinical guidelines for treatment of the patient’s problem. In fact, the approval process is best described as “cookbook,” arbitrary and capricious rather than representative of the patient’s clinical presentation and diagnosis. While we have requested that the **[UM VENDOR]** share its medical necessity and decision-making criteria, no information has been forthcoming. The **[UM Vendor]** prior authorization process is unnecessarily burdensome, offers no functional outcomes assessment, and does not align with the delivery of appropriate physical therapy care.

**[PAYER]**’s subpar management of its enrollee utilization review process and reduced access to medically necessary physical therapist services via its delegation to **[UM VENDOR]** is cause for serious concern. We look forward to establishing an ongoing dialogue to discuss this important topic. Thank you for your time and consideration. If there are questions or additional information is required, please feel free to contact **[NAME AND EMAIL]**.