March 1, 2021

To whom it may concern,

My name is Brandy Hirsch, and I am a current physical therapy patient as well as a practicing Physical Therapist. This letter is about my challenging experience with the insurance authorization process and the uncertainty it has caused in my recovery process.

I initially tore my ACL, MCL, and meniscus in my knee on 3/6/2019 while playing soccer. Due to the severity of my injury, I was placed in a brace and not allowed to weight bear for two weeks leading up to surgery, and an additional six weeks after. I underwent ACL Reconstruction and a Meniscus Repair on 3/20/2019. Unfortunately, I had an abnormal response to surgery and my knee would not bend past about 30 degrees despite initial rehabilitation efforts. On 5/1/2019, I underwent a second surgery, a knee scope for Lysis of Adhesions, to remove the scar tissue that was limiting my movement.

After the second surgery, my recovery routine consisted of formal physical therapy 3x/week, daily physical therapy exercises at home, use of a passive motion machine for knee range of motion 8+ hours per day, ice, and pain medication. Despite these efforts, within 2 weeks of the second surgery, my knee reacted the same and I lost range of motion. I continued physical therapy, while also receiving myofascial release work and using a Dynasplint device for the next three months, 4-6 hours a day. I was seen by a Rheumatologist who tested me for possible underlying autoimmune conditions. Of all these treatments, physical therapy appeared to be the thing that was most effective.

On August 1st, 2019, I finally achieved 90 degrees of knee flexion, **five months** after my initial injury…something that should have occurred in the first few weeks after surgery in a "normal case." It took another four months, until mid-December, **nine months** post-surgery, to achieve full range of motion. Finally, with full range of motion, I was ready and eager to push on to the next phase of my recovery.

At the start of 2020, I began to turn a corner. I was making slow but steady progress. Up to this point, I had been incredibly lucky with excellent health insurance coverage through the hospital system I was employed by. I was able to attend therapy consistently to work on my functional limitations and combat the complications that were limiting my progress. Without that coverage and those PT visits, I cannot imagine where I would be in my recovery.

In May 2020, my fiancé and I moved to Portland. I still was not fully recovered and it was clear more physical therapy was going to be my best solution. It took several months to qualify for our new health insurance. Once we were covered, I immediately scheduled physical therapy. At the time, I would say I was at about 50% of my normal function, still having issues and restrictions with walking, negotiating uneven ground, going down a hill or down stairs, and getting in and out of a car because my knee hurt and it was not strong enough to do it normally.

Upon scheduling my first visit, I found out my new insurance plan required prior authorization for physical therapy to access any of my 20 allotted visit per year. My physical therapist submitted my

evaluation, and I was approved for 6 visits. **6 visits.** After all of the complications, progression, and my current limitations, my insurance believed that 6 visits was all I would need.

Despite this not being enough visits to gain back the remaining 50% of physical functioning, this also tells me, the patient, that either I should be able to get better in only 6 visits, which is misleading and scientifically not feasible, or that I may not get the help I need to fully recover, which is a scary pill to swallow.

From my experience as a physical therapist, I knew that we would have to keep resubmitting for more and more visits. Each time we may get another 6 or a smaller amount. We would have to repeat this process until, eventually, we get denied. Not only does this process make it incredibly hard for a patient to plan their course of care, it causes unnecessary anxiety wondering if they will even be able to get the help they need. This process also requires excess re-evaluation from the treating therapist and wasted administration time seeking authorization. These hurdles can create disruption in treatment planning, potential delays in patient progress, and gaps in care all while waiting on authorization approval.

As a provider, I have spent countless hours on the phone for authorizations and peer reviews. In these conversations, I have had to explain surgical procedures, diagnoses, and treatments to the insurance representative. How can a representative that does not know the details of a procedure or condition make a decision on how many visits are warranted for recovery? These decisions are better left to be made by qualified providers with patient input.

There is not a perfect diagnosis code combination or simple way to portray the severity of the complications of my injury. My injury, like the patients I have treated, is not formulaic. In my own case, I am lucky that I have my knowledge to guide me. However, being a PT does not make me capable of treating myself. As I sit here 2 years out from my injury, I function more like someone who is six months post-op. For this reason, it is even more important to have a skilled physical therapist guiding my rehab now, but instead it is unclear what my path forward looks like. That simply is not fair, and there must be change to the physical therapy insurance authorization process. Insurance frustrations and care cut short by denials cause patients to discharge from therapy at sub-optimal levels. Delays in care while waiting on authorization also have negative consequences for rehabilitation outcomes. As a provider, and now as a patient, I have seen this from both sides.

I hope that my story can help provide context around the importance of an efficient, fair, and clearly defined process for approving visits not just for simple cases, but also complex and involved cases. Physical therapy is a vital component of the healthcare system and we must advocate to make the utilization of it as fair and accessible as possible.

Thank you for your time and consideration.

Brandy Hirsch