Testimony submitted via email.

*As a chiropractic physician who has been on most major insurance panels for the last 10 years in Oregon, I can say without hesitation that the latest switch to pre-authorization has been the biggest step backward for chiropractic care for Oregonians. Pre-*authorizations may make sense for expensive procedures like MRI's and surgeries, but burden the conservative practitioner with unproductive work and "death by a thousand paper cuts".

The following outlines my reasoning for the above statement:

1. It makes no economic sense. Chiropractic care is inexpensive, safe and effective for many painful conditions. Average cost of an adjustment runs from $40 - $70 and many insurance panels bring that fee down to the $35 area. The chiropractic visit takes 7-30 min depending on technique utilized. If I spend 10-20 min filling out a pre-authorization online, I have lost all of that revenue - not a portion.

2. Further, there are denials and medical review. We simply don't get paid enough ($35) to submit reports about *why we think the patient deserves more care* -3 visits into treatment. We further don't have the time or resources to *make appointments with medical reviewers to discus the clinical reasoning – further taking time away for patients. This is just not efficient delivery of care.*

3. There have been several cases presented on this list-serve of the pre-authorization companies not following their own 300-400 page guidelines. After all the work it takes to get the authorizations, and $30-$50 reimbursements, it is really deplorable that this is even a possibility, but it happens on a substantial number of cases.

4. Companies state 'the forms should be filled out by staff'. *This is impossible, since much of the required information is of a clinical nature and front office techs are not trained in this sort of area.* Often when visits are denied, it is due to not enough clinical information being presented.

5. The pre-approval process is a source of great obfuscation and layered beurocracy. Patient thinks they have a benefit, but that benefit is very difficult to use due to the above reasons.

6. It is discriminatory. If a primary care physicians had to do a 10-20 min pre-authorization for every visit in their clinic, the healthcare system as a whole would grind to a halt.

7. It is exactly the wrong direction for Oregonians. Per the Oregon guidelines, chiropractic is exactly the type of care we want to be promoting for Oregonians. At this moment, it is easier for patients to gain access to opiods than conservative management for lower back pain. The cost of this kind of management on patients, families and society has been well documented.

Here is a practical example of a patient at our clinic where these pre-authorizations fail to meet his needs.

Patient 1: 40 year old, male patient with spinal deformities second to radiation and chemotherapy for cancer as a child. Also history of 2 severe car vs. bicycle crashes (him on the bicycle), each taking greater than six months to resolve injuries. This patient has chronic and recurrent pain that is kept at a minimum with exercise, chiropractic and massage care. He comes to the office 6-10 times per year for flair-ups in his pain and to look at new exercise strategies that may help with his pain. Since authorizations always expire at 30 days, we almost always need to do a

new pre-authorization when we see him. This means that instead *of seeing another patient, I need to go online and do a pre-authorization for this patient. Further, the requests for this patient nearly always are not approved right away, but end up in medical review – so we never really know if his visits will be covered. Sometimes they are covered and sometimes they are not.*

I estimate that 20-30% of my practice volume is made up of individuals with history of severe traumas and chronic pain syndromes that we do not expect to remit in the near future.

Statistics will improve (for insurers), but patients will be underserved.

If you were only to look at the insurer payment savings statistics for patients with pre-authorizations needed, you would be impressed if you were a major insurer. Just as you would see the same cost savings for PCP visits if this system were implemented throughout medicine, but it is because people are not getting the care they need, it is not due to decreases in un-needed care. *People are afraid to use the benefit due to the uncertainty of payment.* Physicians can't fight the red tape.

I suspect I am the type of chiropractic physician insurers want on their panels. At least they keep telling me that with chart reviews and statistics they send me. For out difficult cases we are always looking to integrate strategies in additions to chiropractic, like acupuncture, nutrition, emotional health, exercise and pain science. We refer out when necessary to try new approaches when needed. But these patients come to our office because they know the relief they get. The pre-authorization process restricts patients from using a treatment they trust and know works well for them.

Sincerely,

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