Testimony Before the
House Committee on Health Care regarding HB 4102
Presented by Teresa Bailey
on behalf of the Oregon Medical Association
February 4, 2020

Thank you for allowing me to testify today. My name is Teresa Bailey, RN, and I am the manager of the Prior Authorization and Surgery Scheduling Department of Willamette ENT & Facial Plastic Surgery and River Road Surgery Center in Salem. I have been asked to testify before you today to clarify some of the real time problems and issues we face trying to provide timely, quality and cost-effective care to our patients. Our clinic started one of Salem's first Ambulatory Surgery Centers over 18 years ago, moving over 96% of our surgeries from Salem Hospital to an outpatient ambulatory setting. During that time, we have saved the health care system millions of dollars while providing more personalized and efficient care to our patients. Our surgeons and administrator are very active promoting cost effective healthcare in their roles on various boards and committees including the Mid Valley IPA, Northwest Integrated Physicians, Oregon Ambulatory Surgery Association, Oregon Medical Group Management Association, and Oregon Medical Association to name a few.

The increasing complexity of ensuring and collecting payment for medical care has made the provision of care more difficult for health care providers and staff. Utilization management practices, such as prior authorization and step therapy are important tools to contain costs and ensure quality of care. However, they can often result in delayed treatment, abandonment of treatment and higher administrative burdens. Those complexities, coupled with differing authorization processes for each insurer, makes it difficult for both the patient and clinical staff to secure appropriate authorizations in an efficient amount of time.

Prior authorization is a process that requires provider offices to ask permission from a patient's insurance company before performing certain medical procedures or prescribing certain medications. Step therapy protocols require patients to try and fail certain therapies before qualifying for others.

The criteria used for prior authorization are often unclear and vary between insurers; our providers rarely know at the point-of-care if the prescribed treatment requires prior authorization, only to find out later when a patient's access is delayed or denied. Furthermore, providers are often required to repeat prior authorizations for prescription medications when a patient is stabilized on a treatment regimen for a chronic condition.

A survey conducted in 2018 by the Oregon Medical Association showed that 98% of practice managers report delays in care as a result of prior authorization and 89% report that prior authorization can mean patients end up walking away, abandoning the prescription, ultrasound,

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MRI, biopsy, or specialty care all together. A recent survey by the American Medical Association showed that 92% of physicians report that prior authorization can have a negative effect on clinical outcomes.

Every health plan has their own unique set of Administrative Rules, each totaling hundreds, if not thousands of pages. Each patient we see has a unique group number associated with their plan's customized benefit plan detailing their coverage. If you reach into your wallet or purse and pull out your Insurance Card, you will see the beginning of the process we navigate daily.

We are a specialty clinic, so patients likely need a referral from their primary care provider in order to make an appointment with us. If the specialist determines that the patient needs further specialty care, we start the Prior Authorization Process. This means at least one more visit for something we could have done on the same day. 18 years ago, we had one PA employee, a couple of scheduler-receptionists. Now we have 4 PA employees, 6 receptionists and 6 call center-schedulers. They are necessary to make sure we collect and process the information necessary to get paid for the care we deliver to our patients. There is little standardization to the Prior Authorization Process or the clinical requirements necessary to determine if treatment is allowed, let alone a covered benefit. To make matters worse, it is largely a manual process to determine what clinical notes, pictures and diagnostic data are needed. Once the necessary information is collated, it is faxed or mailed to the payor. Yes, faxed or mailed because most payors do not support an online, secure digital data transfer. While the intent of the prior authorization is to prevent unnecessary care, it has resulted in a more than a tripling of our non-clinical staff and adds significant delays to the delivery of care. Rarely, is care denied but when it is, there is another cumbersome process – the Appeal Process. This process is costly to both the payor and the provider and introduces significant delays and frustrations for the patient. We rarely lose an appeal because the care we prescribe is warranted.

I would like to provide a couple of examples of actual cases to help illustrate good intentions gone awry.

Patient A.
On September 26 of last year one of our doctors saw a patient who was having trouble breathing through his nose. The patient also has sleep apnea and his nasal congestion was making it difficult to use his sleep device at night. The doctor determined the patient's problems were caused by a deviated septum and enlarged turbinates. The doctor submitted a preauthorization request for a Septoplasty Turbinoplasty surgery to correct the problem. The PA was submitted to the insurance company on September 27th, using the diagnosis of deviated septum and turbinate hypertrophy.

October 11th, we received a denial for the surgery. The denial stated the surgery was not approval under the patients plan with the diagnosis of snoring. We did not submit that diagnosis because that's not what the doctor was treating with the surgery. The doctor was informed of the denial, so he ordered a sinus CT scan to rule out other pathology that could account for the patient's nasal obstruction. The patient had the CT scan on October 17th, the appeal which included the chart notes and CT results, was faxed the next day.

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December 4th the 1st level appeal was denied by the insurer. It stated that there was no documentation that the patient had tried decongestants or antihistamines. Again, the doctor was informed of the denial. He wrote a letter that day advising that medical management, antihistamines and decongestants cannot be reasonably expected to correct an anatomical deformity of this severity.

On December 5th we sent the letter and requested a 2nd level appeal, this time to the patient's employer as that was next step required by the insurance company.

January 10th, we received approval for the surgery, three and a half months after we started the process.

When we informed the patient that we had the approval he advised us that he had changed insurance companies on January 1. We submitted the request to his new insurance and it was approved the next day.

Patient B.
The second patient I would like to talk about is a young patient, just over two years old. She was seen for enlarged tonsils and adenoids and obstructed breathing, especially at night. The patient also had asthma and allergies were also suspected. The doctor prescribed the nasal steroid spray, Nasonex and asked the parents to bring the patient back in one month for a follow-up appointment. A few hours after they left the office the mother called back and stated the insurance company denied coverage for the prescription. The insurer was recommending the patient use the nasal spray Flonase instead. The doctor sent in the prescription, but he advised the parents to discuss that with the pharmacist as Flonase is likely safe but is not technically indicated for a two-year-old.

The office staff sent in a preauthorization request for the original prescription, the Nasonex. We received a denial the following day from the insurer. The denial stated that a pharmacist licensed with the insurer had reviewed the patient's chart notes and determined the patient must try step therapy first. They advised that the patient must use two of the following nasal sprays: Rhinocort, Nasarel, Flonase, and Nasacort.

The mother called the office and advised us that after talking with her pharmacist she decided she did not want to give her child the Flonase. She asked that we appeal the denial of the Nasonex.

We submitted an appeal to the insurer, advising them that that Nasonex is the only corticosteroid nasal spray approved for a two-year-old. Two days later they approved the prescription.
This entire process took 19 days when it should have only taken 2 or 3. The insurer pharmacist should have known that the nasal sprays they required in their step therapy were only approved for children over age 4. In fact, only the Flonase is for children age 4 and over. Two of the others they were requiring are for age 6 and the other is for children age 12.

Since the patient had not been using the medication, her follow up appointment had to be rescheduled. Her course of treatment was delayed by nearly a month just because the insurer did

not take her age in to consideration before they denied her prescription and required step therapy with medications that were not even approved for a child of her age.

These are only two examples of the many similar situations we must deal with every day.

HB 4102 seeks to ensure that the prior authorization process is transparent, efficient, and fair – using evidence-based practices that best supports the health needs of the patient. The key concerns addressed by HB 4102 are to prevent treatment delays and treatment abandonment.

I would like to thank you once again for the opportunity to address the committee regarding this very important topic and I'm happy to answer any questions.

The Oregon Medical Association serves and supports over 8,200 physicians, physician assistants and student members in their efforts to improve the health of all Oregonians. Additional information can be found at www.theOMA.org.

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