OPTA
OREGON PHYSICAL THERAPY ASSOCIATION

Testimony in Support of House Bill 4102

To the House Health Care Committee
February 5, 2020

On behalf of the 1,700 physical therapist, physical therapist assistants, and student members of the Oregon Physical Therapy Association (OPTA), the OPTA submits this letter in support of HB 4102. The OPTA is happy to join a coalition of patient advocacy groups and provider associations in an effort to improve transparency, efficiency and fairness in the utilization management process.

Over the past six years, our patients and providers have noted a proliferation of utilization management programs intended to prune wasted or inefficient care from the health care system. *Unfortunately, the majority of these programs are poorly targeted and result in unnecessary and costly delays in medically necessary treatment that often negatively impact the result of care*.

Transparency –

Patients assume that health insurance will cover medically necessary care within the coverage limits of the policy. Many patients understand their policy's visit limitations but are surprised to learn that treatment will be delayed because a third party contracted by their insurer must review and approve all treatment. HB 4102 seeks to address this issue by requiring payers to make their prior authorization requirements available to members in clear language on their website.

In conversations with these utilization management organizations, the OPTA has routinely been told that > 90% of requests are approved which suggests that the review process isn't targeted appropriately. The bill requires public reporting of metrics, such as the number of requests and approval ratio, in order to encourage an appropriate level of utilization management and remove the unnecessary speed bumps in the pathway to critical care.

Efficiency –

In an era where critical data are documented electronically, electronic portals and interfaces should be available to improve both accuracy and efficiency. Data should be evaluated by an algorithm and appropriate care should be authorized immediately. If more information is required, the clarifying criteria should be clearly presented to the

provider and the process for scheduling with a peer-reviewer who has expertise in the patient's condition should be timely. HB 4102 encourages the use of electronic data exchange and places parameters around acceptable timeframes for authorization determinations and appeal reviews.

Fairness –

Utilization management decisions are often made under obscure or outdated criteria. As an example, a student athlete undergoing physical therapy following ACL surgery had her appeal for additional treatment denied despite clear evidence of continued improvement in treatment and need for continued care. The patient had documented deficits in quadriceps strength ratios which have been shown to be the prime indicator of successful recovery after this surgery. With her rehabilitation cut short, the athlete returned to the field to continue her strengthening program without supervision and re-ruptured the ACL, resulting in a second surgery. Clinical determinations should be made on the best evidence available and appeal processes should be available to ensure that patients receive the care they need.

The legislation is NOT intended to:

- Ban the use of utilization management protocols
- Require creation of new clinical guidelines for utilization management
- Change the benefit design of insurance plans in relation to utilization management
- Address provider networks or hinder insurers or providers developing other provider-driven alternatives such as preferred provider programs or attestation of appropriate use criteria programs.

Thank you for your support of HB 4102,

Chris Murphy, PT
Chair,

OPTA Government Affairs Committee

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