ROSE CITY
PHYSICAL THERAPY
ORTHOPEDIC • SPORTS CARE • WELLNESS

Testimony in Support of Therapy Amendments to HB 3134

Chair Representative Nosse, Vice-Chairs Representative Javadi and Representative Nelson, and Members of the Committee:

My name is Sasha Kolbeck and I am a physical therapist with 26 years of experience and a small business owner of a clinic specializing in orthopedic physical therapy for individuals recovering from conservative and post-operative orthopedic diagnoses.

I strongly support the therapy amendment to House Bill 3134 regarding prior authorization for physical, occupational, and speech therapy services. This amendment is critical to ensuring that patients receive timely, uninterrupted care without the administrative delays that too often hinder their recovery, and place staffing and financial burden on an already limited workforce.

As you may know, prior authorization requirements are meant to ensure that healthcare services are medically necessary. However, in practice, these requirements often lead to significant delays in care and increase clinic expense and practitioner burnout. This is particularly harmful in therapy, where research shows early and consistent treatment is crucial to recovery and long-term health. In addition, staffing is limited and business margins are slim. Many patients do not realize their plan has an authorization process and see the plan allows certain visits per year and assume they are able to use those visits if medically necessary. We recently sent a survey on prior authorization to Oregon physical therapists. Our survey data shows approximately 40-50% of patients require authorization. There is a greater than 90% approval rate with the first request, so why is the process required at the first visit? The first request typically authorizes 8-12 visits. The total approved visits after three requests is typically 14-19 visits. With the prior authorization requirement for the initial request that has an extremely high approval, this shows the administrative hurdle that increases operational cost for the practitioner and insurance and often leads to significant delays in care. On the clinic side, the process takes staff to track and submit authorizations, schedule appeals, and handle insurance's authorization errors such as authorization start date errors, which increases administrative burden, but also delays payment and patient access. Data from our Private Practice Section of the American Physical Therapy Association reports that 80% of practices employ non-clinical staff who work on prior authorization and 40% work exclusively on authorization. Small businesses like mine, cannot afford this, due to declining reimbursement, so the burden falls on the owners after their patient care hours in the evening and weekends. My estimated time is 15-20 hours per week. Each authorization request submission takes 15-30 minutes. The appeal process can require multiple levels (phone call peer to peer, written appeal, and written independent appeal) with the patient

care needing to be held during this time which is a week to 4 weeks depending on the level of appeal and the insurance. For acute and postoperative patients, this delay or denial of access to care can impact the outcome. Our Private Practice Section states that therapists report the authorization process has at least sometimes led to a patient abandoning their treatment 79% of the time. There is an argument that therapists need the authorization process to not over utilize, which is not only disrespectful to our ethical obligation, but also is not a concern of by local payers who know us best including PacificSource and many MODA plans, as they do not require authorization, or in the case of certain MODA plans, a medical necessity request is needed after 25-30 visits. There are the additional issues of denials despite having authorization which requires work to fight and delays payment which is a hardship for a small business. One payer denied claims for 60 patients with multiple dates of service which required reporting to the Insurance Commissioner showing proof of authorization for all claims, with payment taking over a year which was a financial burden. When I pointed out that we still hadn't been paid on a claim, the payer said to me, "You cannot expect to be paid for every claim. Report us". Therapist's time should be spent caring for the patient.

Our ask is a waiver for the initial 16 visits in an episode of care prior to authorization being required for physical therapy, occupation therapy, and speech language pathology. Also, transparency by payers that authorization is required and what the process entrails along with penalties to payers for delayed payment and wrongful denials.

In closing, I urge you to re-consider the therapy amendments to HB 3134. These changes will reduce administrative burdens and provider burn out, increase financial viability of small business physical therapy, improve access to timely care, and ultimately enhance the health and well-being of our patients.

Thank you for your time.

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