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HOUSE HEALTH and INSURANCE COMMITTEE TESTIMONY

Re: HB19-1211, Prior Authorization Requirements Health Care Service

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Representative Lontine, Representative Caraveo, and other distinguished committee members, thank you for this opportunity to speak in strong support of HB19-1211. For twenty years, I was the individual in our company tasked with submitting requests for prior authorizations and for the last three years I have acted as the trainer for the Commercial Insurance Authorization Department.

Passage of this bill would be a boon to both patients in need of healthcare services and the providers of these services. Currently the process is extremely labor intensive. Staff must have knowledge of the many utterly divergent protocols required by different utilization management entities.

1. Currently, the exact same service might be authorized for a year or the provider might be required to fax a treatment note after each date of service in order to receive authorization for the next date of service.
2. The method of submission is as varied as the number of utilization management companies. Some require person to person requests, while other require faxed, electronic or mailed submissions.
3. To assure understanding of a benefit, providers (and patients) need to scrupulously read the applicable Evidence of Coverage, digging deeply into Limitations and Exclusions, which are not explained by the customer service benefit review process unless specifically requested. An example occurs when a policy holder or provider asks about the physical, occupational, or speech therapy benefit in many Cigna policies. The caller will be given deductible, copay, or coinsurance information, the out-of-pocket maximum, and the visit limit, but unless the caller is knowledgeable enough to request a reading of the Limitations and Exclusions language, they will miss the fact that the policy actually only covers therapy that is “restorative” in nature. Thus, if the patient is a child with a developmental diagnosis where skills have yet to be developed, no therapy is covered, yet that fact will not be known until the provider accepts the patient, gathers the intake information, receives the doctor’s order, staffs the patient, does an initial evaluation, and prepares and sends the prior authorization request to the utilization manager.

Incentivizing providers who are diligent in requesting services that are actually medically necessary, appropriate in scope and duration, and submitted appropriately is also an excellent idea. This bill would streamline the prior authorization process while increasing the quality of the outcome. Thank you for your attention to this important issue and for allowing me to offer my perspective.