I am testifying in favor of Rep Potter's bill, H 5120 on prohibiting prior authorizations for primary care physicians ordering tests within network..

Honestly, I do wonder if there will be an uptick in ordering CT scans and MRI's and other test if this bill is passed. Additionally, from what I understand, RI Medical Imaging may not even be able to handle the extra business. Even the hospitals are having a hard time staffing their radiology departments, despite very good reimbursement.

On the other hand, very recently, all in the same week, I had a denial for a neck MRI for bilateral hand numbness and another denial for a belly CT for 2 months of LLQ abdominal pain that were absolutely ridiculous. In another case all in the same week, I had a neuro-ophthalmologist and a general ophthalmologist of the same patient recommend a CT of the chest in a heavy smoker to evaluate for a possible lung cancer related immunological disease that also got rejected.

If this bill is approved, I know the insurance companies will save money not paying their reviewer services. In fact, the reviewer services themselves may be the most ardent behind-the-scenes supporters of continued reviewing and denials.

The insurance companies can still send physicians their opinions as to whether or not they think the test is inappropriate without having the power to hold up the test. The insurance companies may also want to send physicians feedback on any increase in ordering year over year. No legislation is needed for these ideas. Docs like feedback and truly want to do the right thing and don't like being outliers.

*****A major problem with the entire prior authorization process is that the insurance companies somehow have no liability for denying a service, so if they want to continue doing it, perhaps they would be willing to accept liability for a denial causing a delay in care?*****

The times I and the reviewer ended the session in disagreement, they always tell me I can somehow appeal it again. As legislators, who have responsibility for how healthcare is provided to your constituents, I just want you to know that at this stage that I've done enough, I'm sick and tired of

this process, burned-out, if you will. Sometimes I tell the patient what happened. Sometimes I just wait for the patient to see the specialist after me and let them try to get the test, which means a delay in care and waste of the consulting physician's time. I also make an audio recording each session for my own use, so if anyone here wants to hear how these sessions go down, just let me know.

Additionally, the insurance companies have no responsibility for wasting the time for the **physician** who has to spend time with the reviewer. Perhaps, if the insurance companies want to continue the whole appeals process they could agree to pay us perhaps a 2 office visit codes considering the disruption to our practice and time and added stress and extra work required dealing with a denial.

Additionally, as you know, it is also a "moral injury" to the physician who has to deal with another person who has never seen the patient and does not have a relationship or sense of responsibility to the patient, and justifies their own **job** by denying care according to a guideline, that the insurance companies uses as clinical rules. The guidelines are only meant to be guidelines. Every individual case has it's own merits.

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