
Public Hearing

before

ASSEMBLY POLICY AND REGULATORY OVERSIGHT SUBCOMMITTEE ON AUTOMOBILE INSURANCE

*“Testimony concerning the proposed rules to implement
the ‘Automobile Insurance Cost Reduction Act’”*

LOCATION: Committee Room 11
State House Annex
Trenton, New Jersey

DATE: October 27, 1998
2:00 p.m.

MEMBERS OF SUBCOMMITTEE PRESENT:

Assemblyman Paul DiGaetano, Chairman
Assemblyman Gary W. Stuhltrager, Vice-Chairman
Assemblyman Wilfredo Caraballo



ALSO PRESENT:

David L. Sallach
*Office of Legislative Services
Subcommittee Aide*

Jon-Robert Bombardieri
Jarrod C. Grasso
*Assembly Majority
Subcommittee Aides*

Tim Clarke
*Assembly Democratic
Subcommittee Aide*

Hearing Recorded and Transcribed by
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ASSEMBLYMAN PAUL DiGAETANO (Chairman): Can I have your attention please. Ladies and gentlemen, I am going to have to ask everyone who is not seated and not a member of the press to either take a seat or please file out of this room. State Police will not permit us to have these aisles occupied by those who are standing. So we would ask that if you don't have a seat and you are not a member of the press, please step out of the room. As soon as we get that order, we will begin our hearing, and we will begin with the Commissioner of the Department of Banking and Insurance. Please give us your kind cooperation at this time and we can begin the meeting.

Sergeant Huertez, are we ready to begin?

SERGEANT HUERTEZ: Yes, sir.

ASSEMBLYMAN DiGAETANO: Thank you very much.

Ladies and gentlemen, I thank you for your kind attention. For those of you who are unaware of the Committee's membership, my name is Paul DiGaetano. I am the Majority Leader in the Assembly, and I am joined on this Committee by Assemblyman Gary Stuhltrager, who is the Assembly Parliamentarian, and by Assemblyman Wilfredo Caraballo, who is the Associate Minority Leader in the Assembly as well.

This Committee is a Subcommittee of the Assembly's Policy and Regulatory Oversight Rules Committee established by Speaker Jack Collins for the expressed purpose of overseeing and reviewing regulations to be promulgated by the Automobile Insurance Cost Reduction Act. This Committee is not currently entertaining any resolution, oversight, or other.

This Committee is taking testimony on this issue with one purpose and one purpose only. The charge by the Speaker is to ensure that the people in the State of New Jersey get their guaranteed 15 percent rate reduction in

auto insurance premiums without compromising their necessary medical care as the sole charge of this Committee.

Keeping that in mind, we will take testimony today beginning with our Commissioner from the Department of Banking and Insurance, a relatively new Commissioner, but not new to state government, and we welcome her today to these hearings. We have a lengthy list of witnesses, so I would ask for your kind cooperation. I would advise anyone who is here to listen to testimony and also to present testimony to be aware that this hearing today will not go on until the wee hours of the morning. We anticipate that we will close taking of testimony around 5:30 p.m. today. We will take as much testimony as we can, and we will schedule additional hearings as may be required to get all our witnesses in as they so choose. We invite any of you who have prepared testimony, especially those who may not be able to get before the Committee today, to submit your written testimony. And I assure you as the Chair of this Subcommittee that this Committee, each member and staff, will review in its entirety your presentation of testimony to this Committee.

Without any further ado, Commissioner, we welcome you to this Subcommittee, and we ask for what we will consider a brief overview of how the Department reached the point of the proposed regulations. And I understand your intention is to address some misconceptions that may be out there in the public as well. And once your testimony is done, we will have questions from the Committee members as they deem appropriate and then move on to other testimony.

Good afternoon, Commissioner.

COMMISSIONER JAYNEE LaVECCHIA: Thank you, Assemblyman DiGaetano and members of the Subcommittee. I am very pleased to be here today in front of you to speak to the Department's proposed regulations to implement the 15 percent auto insurance rate rollback that is required by the Legislature's enactment of the Automobile Insurance Cost Reduction Act enacted last May of this year.

I will take a moment to outline the concepts that are at the heart of these regulations and the nature and substance of some of the comments and dialogue we have been having with the public to date.

As required by the auto reform legislation, the Department has developed regulations that do a number of things: to create a new basic insurance policy, to create new lower limits of personal injury protection coverage, to create an independent alternative dispute resolution process to resolve questions about medical treatment more efficiently, and to create protocols to address known problems of overutilization and fraud with the goal of eliminating a perceived 25 percent of unnecessary costs from the personal injury protection system.

Assistant Commissioner Don Bryan and I are here today and are prepared to discuss all of these regulations with you; although, I will be limiting my comments to the medical protocol regulations.

One does not have to be involved with the insurance industry for long, members of this Committee know, without knowing that fraud and overutilization plague our system. An independent study of states that have PIP coverage found that the average cost to treat whiplash here in New Jersey was \$5933. That amount is more than twice the national average. We have

the highest average length of treatment and the highest average number of doctor visits per claim. The latter, the average number of doctor visits per claim, is almost as twice as high here than in the national average

The Legislature obviously was aware of this problem and debated it extensively this past spring and in the reform Acts said the following. “Since the enactment of the verbal threshold in 1988, the substantial increase in the cost of medical expense benefits indicates that the benefits are being overutilized for the purpose of gaining standing to sue for pain and suffering, thus, undermining the limitations imposed by the threshold and necessitating the imposition of further controls on the use of those benefits and the establishment of a basis for determining whether or not treatments or diagnostic tests are in fact medically necessary.”

The Department thus approached the task that it was charged with, with two goals in mind, and they are as follows.

1. Take costs out of the personal injury protection system and reduce unnecessary costs.
2. Do so while preserving the ability to treat those who are truly and severely injured in an accident.

We believe that the proposed medical protocol regulations serve those twin goals and serve them well.

The medical protocols, and this is the most important concept that I would like to convey to this Committee today, set up a baseline, or a guideline, for approaching what is medically necessary treatment for accidents involving injury to the neck and to the back. Treating medical practitioners will have, through the use of these protocols, clear guidance on what course of

treatment will be regarded as reasonable and customary for these type of injuries. And practitioners and insurance companies considering these kinds of issues together will be able to determine more easily whether or not unnecessary medical treatment is in fact taking place.

Point two about these regulations. They are in line with accepted professional practices. They were prepared by a health benefits consultant per the suggestion of the Legislature in Section 4. After we had the benefit of that, the assistance of the health benefits consultant, they referred to an extensive bibliography of learning the (indiscernible) that assisted them in the preparation of these materials. They use nationally accepted industry management guidelines, professional articles, and other articles from multi-disciplinary professional sources.

Point three, these medical protocols call for the injured person's health-care provider to make the initial determination of the necessity of treatment. We are not taking that pole away from the practitioner that is working with the injured person.

Last but not least, these regulations do as the Legislature described with the assistance of the Medical Board and some other professional licensing boards. Tests were identified, and these tests were identified as having no diagnostic value and therefore will no longer -- if these regs are adopted -- will no longer be susceptible for reimbursement through PIP.

The reaction that we've had to these regulations has been both supportive as well as contrary. We've received numerous helpful, instructive, and positive comments from interested parties, and I will be telling the Subcommittee about that in just a bit. But there has also been an organized

effort that has provided some misinformation that's caused fear, concern, and in fact, even public anger at the Department's good faith effort to implement the legislative charge in the painfully short time that we had to accomplish this project. The misinformation, I'm afraid, comes not surprisingly from the special interests that stand to lose the most as we tighten up the system.

PIP coverage is going to pay now for what it is supposed to pay for, and that is for providing medically necessary treatment only. That's what the statute calls for, and that's what we intend to implement through these regulations.

I'd like to address a couple of the misunderstandings so that we can remove the misunderstandings from any discussion hopefully that there is necessary with this Committee. One example, we received a pack of 65 form letters all from the same chiropractor's office and signed by patients claiming that insureds could not choose their own doctors for treatment. Well, that's just flat-out untrue. If you look at the regulations, there is no reasonable way anybody could read those regulations to suggest that their patient's choice of health-care provider would not be permitted. There is no restriction on choice of provider in N.J.A.C. 11:3-4.5(a). And if you also look at the definition of health-care provider in the regulations, Section 4.2, you'll find that it matches exactly the definition of health-care provider in the Legislature's definition of the same term, Section 2.1.

Another misunderstanding, insurance companies will decide what is, and what is not, medically necessary treatment and will dictate to the medical provider what services to provide. Fact, the medical necessity of treatment is going to be determined by a physician and other health-care

professionals. The initial course of treatment, as I mentioned, is determined by the treating provider based on simple symptoms, diagnosis, and indications found with the patient. But in accordance with the Act and the rules, the continuing course of treatment and the administration of certain diagnostic tests will be subject to review by a physician of the insurer. And that's in 11:3-4.7. Disputes are going to be resolved by an independent medical review organization physician, not just any old employee from the insurance company as has been alleged. And this independent physician is going to advise an equally independent alternative dispute resolution professional on the medical necessity of the treatment, and that individual ultimately will resolve that dispute. That's at 11:3-5.

Another misconception, any treatment that is deemed necessary by the treating medical provider but is not referenced in the care path will be denied by the insurance company. Well, that's not how those medical protocols and the care paths are set up. Treatments that vary from the care path are reimbursable by the insurer when they are medically necessary, tied back to the same language that appears in the statute. It appears at N.J.A.C. 11:3-4.5(a). That section specifically says that PIP coverage will reimburse all medically necessary expenses. And then for further comfort, if you look at 4.6(c), that specifically provides that medically necessary treatment that varies from the care path is reimbursable.

Four -- this is the last misconception I will trouble the Committee with today.

ASSEMBLYMAN DiGAETANO: No trouble at all.

COMMISSIONER LaVECCHIA: Hopefully.

The rules limit objective diagnostic testing to a specific list. Repeat diagnostic testing is arbitrarily prohibited without regard to medical necessity. Fact, the rules do include a list of diagnostic tests for which no reimbursement will be made because we've been advised by the professional boards that these tests yield no data of any significant value in the development, evaluation, or implementation of an appropriate treatment plan. Those tests are listed at 4.5(a).

This list includes many tests that, over the years, have cost millions of motorists' premium dollars. And while some of those tests may have been valuable in the context of a lawsuit, they should have not been paid with PIP premiums. The Rules also set out a list of diagnostic tests that may be valuable when medically necessary and politically supported. Those are listed at 4.5(b). The Rules set forth limitations on the normal use of those tests consistent with good practice. Again we were advised here by the professional boards, and they will be adopting their own rules separately to bolster what appears in Title 11.

The rules specifically permit variance, again based upon clinically supported findings in particular cases. So there is that safety valve to protect against the individual case that needs a particular treatment and the treating doctor can so demonstrate against appropriate standards. That's provided for in 4.5(c), and it's also provided for in the context of emergency care in 4.5(e). The list of prohibited tests and the limitation on valid tests were developed, as I said, in consultation with those professional boards, and that consultation continues as we speak and will continue throughout the process until we come to a fully adopted rules. And, frankly-- And, members of this Committee, that

consultation will continue thereafter because it was anticipated in the legislation that these rules would be constantly reevaluated and updated as necessary.

I'd like to get back to the helpful public dialogue that has been going on in the notice and comment period as the Administrative Procedure Act was intended to have happen here. As I said, we've used knowledgeable consultants that assisted us in this process. We conferred with the leadership of the professional boards and the full boards in dealing with the diagnostic tests. We've held many individual meetings already, myself and other members of my staff, with various professional organizations. And during those meetings, we've conducted literally hours of what I consider to be productive dialogue in discussing the rules' language and also how practically they would be implemented. It has been extremely helpful to us, and I thought from the way those meetings went it was helpful to those organizations as well because we dispelled some misinformation.

But we've also received many, many, written comments, and I suspect you have as well. We are going to be conducting a public hearing next week, so we will be getting additional information through that vehicle. The bottom line is that I am trying to tell the Committee that we've had good input, that it's been a productive process, and that the process is working. We think the rules are sound, and we recognize that they will benefit by clarification and response to legitimate concerns or pointing out of ambiguity.

I'd like to mention a few of the clarifications that I know already that we are going to be making come the time for adoption. And, in fact, we

have already indicated these points to several groups with whom we have met. I would like this Committee to know it as well.

One of the first changes we are going to do is revision to the conservative therapy block in care path 1, 3, and 5 in order to describe more clearly, since it wasn't coming across as well as we thought, that the course of treatment be understood as a baseline, as I have described already to the Subcommittee. These protocols are meant to be guidelines for what is medically necessary treatment in most circumstances. And the clarification will also account for those instances where the chiropractor happens to be the treating health-care provider. That's an important revision to that group. It will clarify that spinal manipulations and physical modality treatments, which are now currently shown separately, can actually be combined into one overall number when it is a chiropractor who is the primary treating practitioner. What that will do is make clear that the total number of chiropractic and physical modality treatments during the course of a 30-day conservative therapy period can be as many as one to three times per week.

Another revision to the same care paths 1, 3, and 5 will describe more clearly the course of treatment when an osteopath is the treating physician. This is very similar to the change I just mentioned with regard to chiropractors, and it recognizes that osteopathic spinal manipulation is a part of the conservative treatment course during the first 30-day period, and we've indicated as such to organizations.

Three, we are going to be revising the decision point review and precertification rules to encourage insurers to accept a comprehensive treatment plan in lieu of decision point review at specific intervals and also to

encourage precertification of individual treatment plans. We believe that such approvals, in certain context, will be more appropriate and a more efficient way to process than to proceed in those certain instances.

Four, we are going to be revising the rules to clarify that the need for emergency treatment at a hospital following an accident may be necessary, not just at the immediate time of an accident. We realize that there may be a reasonable time after the accident happened when someone realizes that they need emergency care. Sometimes the symptom is somewhat delayed or someone just is not being sensitive to the problem. Several hours later, 24 hours, 48 hours -- I don't know what the time is at this point, but some reasonable time thereafter there needs to be access to emergency room treatment. We don't want to create any confusion about accessibility to emergency care.

Five, we are going to be revising the rules to confirm that such matters as general health or preexisting conditions may affect the proper course of treatment that will be required and that may be then medically necessary and will cause a variance from the care path. That is appropriate, and the clarification will ensure that that will be able to happen.

My point is that the dialogue in conversations that we've been having and all of the formal comments that we have received have made this comment process a good one. It's been productive, as I said. It will strengthen the rules, and it will better serve the legislative purpose, we believe, in addressing the need for a standard, or baseline, course of treatment in PIP coverage. It will help to eliminate the plethora of disputes that we still have to date without the availability of a medical protocol to assess what is medically

necessary in this particular setting, again neck and back injury only. That's the only injuries that are covered by these protocols.

The point is, though, PIP coverage is never going to be unlimited again and nor should it be. Even in traditional indemnity plans, everyone understands the concept of reasonable and customary treatment. And they also understand that it is what is reasonable and customary that's covered and what deviates from that is not. There is nothing startling about this concept, and there is nothing un-American about it. It's a good concept, it works, and it's time that its uses migrated to the PIP system. And it's also time that the participants in the PIP system understand that those concepts can, and should, work in this setting.

I welcome the opportunity to come before this Committee and to tell you what these regs are all about from the perspective of myself as Commissioner and on behalf of the others in the Department who have worked on this. I would ask the Committee to please not respond to any imprecise paraphrasing of the regs that may only have the result of distorting what the regs are really about and perhaps lead to condemnation for what is not truly the language of the reg nor its reasonable interpretation and how it will be implemented.

Our intent is to provide an appropriate set of guidelines for treating those who have been injured, while having the necessary tools to weed out those who are using unnecessary treatment for personal gains. We've all seen the cases, the staged accidents, the excessive medical bills, the liability lawsuits predicated on unnecessary medical bills. None of us likes it, and I think all of us are united in trying to find the appropriate way to stop it but,

of course, without impeding the -- and I'm going to quote from the statute -- "most appropriate standard of care for the truly injured." It's not just anybody's standard of care anymore. It's going to be based on more objective criteria.

The Legislature directed us to have these rules out for public discussion within 120 days. We met that date. It requires them to be in place by the end of the year. It's only by meeting that schedule that we will be able to be in a position to roll back rates effective for the New Jersey citizens in March of next year. That's what the Legislature wanted as I understood it. That's what the people of New Jersey want, and that is what we want to accomplish as well. So barring any delay, these premium cost savings will be available to citizens in New Jersey in March, and I am proud to tell this Committee that.

In closing, let me say thank you very much for the opportunity to come and talk to you about the rules in this very deliberative setting and to have this direct conversation with the Legislature about it. I'd be please to answer any questions that I can and so will Assistant Commissioner Bryan about these proposed rules.

And with that, Assemblyman, I'd like to allow, if you would, Assistant Commissioner Bryan to speak shortly about the other rules that are in the package that the Department has put out.

ASSEMBLYMAN DiGAETANO: Please, do.

ASSISTANT COMMISSIONER DONALD BRYAN:
Thank you, Commissioner.

Thank you, Assemblyman.

Your Hearing Notice-- (witness pauses)

ASSEMBLYMAN DiGAETANO: If the light is on, your mike is working. (referring to PA microphone)

ASSISTANT COMMISSIONER BRYAN: The Hearing Notice referenced not only the protocols rule, but three other rules that we proposed. One of them was the basic policy rule, which provides the outline of the new basic automobile insurance policy. Just one item I wanted to mention on this -- I'm just going to touch on these other rules briefly -- that our intent in developing the PIP standards, for both the basic and the standard policy, was that, in fact, the quality of medical care be the same for both the basic and the standard policy -- there not be inferior care under the basic policy. That, in fact, the difference between the basic policy limits and the standard policy be only the policy limit -- the total amount of dollars of cost of care, not some difference in the quality of care that's provided.

The second set of rules was a comprehensive set of changes to existing rules that conforms the Department's current auto insurance rules to reflect the statutory changes in the new law. There were a few other technical changes in making that, but primarily it was intended to reflect the new statutes.

And the third -- or the fourth rule that was on your list was the PIP dispute resolution rules. These rules implement Sections 24 and 25 of the Act to provide a new system for resolving PIP disputes. Most of the rules in our package are structural, or procedural, to provide for the designation of a dispute resolution organization to administer the process, describe the role of the full-time dispute resolution professionals that decide the cases, and provide

for a review of medical issues by a medical review organization that issues a report to the dispute resolution professional.

Thank you.

ASSEMBLYMAN DiGAETANO: Anything further, Commissioner?

COMMISSIONER LaVECCHIA: No, Assemblyman.

ASSEMBLYMAN DiGAETANO: Thank you.

I have one question and really one question only at this time, Commissioner. I heard you mention in your testimony a number of times that the Department consulted with and actually had the professional boards establish a list of approved tests, diagnostic tests, etc. I would like you to address -- if you would expand on your testimony a bit with regard to the protocols that were set up. It has been mentioned to me, and I did not hear you in your testimony encounter this, that the professional boards did not have the opportunity to pass on, if you will, to use that term, the protocols that were established. And I'd like you or a member of the Department that you so choose, since it was probably done before you came on board, to address that issue.

COMMISSIONER LaVECCHIA: I'll start, if I may. The medical protocol rules and the diagnostic test rules were both on the 120-day schedule. The protocol rules were drafted with the assistance of the Pricewaterhouse Coopers people, as I mentioned earlier, and we had 3 days, essentially, from when they were received to get some kind of comment not only from the Department of Health, but also from the Division of Consumer Affairs. We were able to get some comments back from the Department of Health people,

and we received some cursory comments -- I have to call them cursory because of the amount of time we had -- from staff of DCA and I believe at least one, if not others, members of some of the boards may have been contacted in an informal way. But there was no opportunity during that short time frame for there to be a deliberation of those bodies to come together and give us a comment. We have since been having some conversations with them. As a matter of fact, on Thursday I'm meeting with representatives of the Board of Chiropractors over these specific rules. We had intended that consultative process to continue throughout the comment period and we are doing that. There is a separate meeting being set up with the Board of Medical Examiners.

ASSEMBLYMAN DiGAETANO: Thank you.

Any members of the Committee-- Assemblyman Stuhltrager, do you have any questions of the Commissioner or staff?

ASSEMBLYMAN STUHLTRAGER: Let me just ask really the same question almost as Paul asked with respect to the development of the care paths and who participated, and to respond to the criticism that it was not inclusive of all groups. Specifically, we have received communication that the chiropractors feel that they were somehow disenfranchised in that process.

COMMISSIONER LaVECCHIA: I know all of these members of the Subcommittee very well, and I know that you are familiar with the rule-making process. It is not always possible to make all groups feel included, particularly when you have a very short time frame to (laughter from audience) create the first draft of--

ASSEMBLYMAN DiGAETANO: Ladies and gentlemen, regardless of how you may feel with respect to testimony being presented by

this witness or any other witness today or by any member of this Committee, we will not permit any outbursts such as the one we have just experienced. Unfortunately, if you choose to do that again, I will have to ask the room to be cleared, and I don't think you want to do that. But please give this witness and this Committee courtesy that is appropriate.

COMMISSIONER LaVECCHIA: If I may continue.

ASSEMBLYMAN DiGAETANO: Yes.

COMMISSIONER LaVECCHIA: I want there to be no misunderstanding with this Committee. The consultation with members or representatives of those boards was limited, no mistaking it. And the conversations with the professional groups have been occurring since we proposed the rules and put it out for all public consumption and discussion with all interested parties.

We were not able to, and I can't apologize for it because I don't think it was feasible, Assemblyman, have those kinds of meetings with professional groups in the short time that we had to prepare the first set of the proposals that went out -- and this was the first set of proposals that went out. But that discussion has been ongoing, it's been meaningful, and it's absolutely consistent with the requirements of the APA. There has been no violation of the letter or the spirit of the public dialogue that was intended by the APA.

ASSEMBLYMAN STUHLTRAGER: Perhaps the most fundamental reason for this hearing, and the most basic criticism of these regulations, is that the Department, the administration, whatever is attempting through regulation to do what they had really failed to do through legislation. And I really would just like your response to that. Whether it be in specific--

I know in your testimony you did cite the section that I believe you're relying on. If there is anything else that you are relying on or whatever response you would like to give to that very basic criticism as opposed to the specifics that are within the protocols--

COMMISSIONER LaVECCHIA: If I understand how you are describing the criticism, if it is that we are doing -- we are putting forward a medical protocol that sets out a baseline of treatment, that's exactly what we are doing, and that's exactly what I understood the legislative language to require.

ASSEMBLYMAN STUHLTRAGER: Let me explain the criticism in another way then. It's that a managed care system was rejected by the Legislature, allegedly, through the legislative process, but that the administration has chosen to regulate a managed care system; whereas, they cannot legislate it.

COMMISSIONER LaVECCHIA: I absolutely disagree with that.

ASSEMBLYMAN STUHLTRAGER: Okay.

COMMISSIONER LaVECCHIA: This is not a managed care system. We don't have gatekeepers telling people who they can see. I thought I just covered that by saying that providers are not limited. People have the right to choose their providers. But they do have to expect that those providers must explain their course of treatment when the insurer's physician is questioning whether or not the treatment is consistent with nationally accepted standards and other professional treatise that set guidelines for what is accepted and what is not accepted with regard to neck and back injuries.

We're asking people to explain themselves, yes. I don't think that's the same as managed care.

ASSEMBLYMAN STUHLTRAGER: Thank you, Commissioner.

COMMISSIONER LaVECCHIA: Thank you.

ASSEMBLYMAN DiGAETANO: Assemblyman Caraballo.

ASSEMBLYMAN CARABALLO: Good afternoon.

Just a couple of questions and I have a comment, a very short comment I assure you. But what basis-- You explained that we didn't have much participation by the professional community because of the short time period. What was Pricewaterhouse's expertise in being the ones that set up the system?

COMMISSIONER LaVECCHIA: They're health benefit management consultants, and they have a variety of experts available to them. We worked with three physicians, one of whom is also a D.O., and some other professionals. I don't have their credentials -- all of them -- off the top of my head, but they worked primarily with us in the development of the care paths using a bibliography of materials, which I am prepared to share with the Committee so you know what references they were using when they reached the conclusions that they have.

I should tell you that the protocols have been endorsed by other professionals who have since looked at them. There are some experts that will be in a position to talk about, hopefully in the near future -- that have done an independent review of the protocols and have said that they are good, they are consistent with other national standards. In fact, the only criticism that we have received is that they may be a little too liberal.

ASSEMBLYMAN CARABALLO: Would they-- Do you think that their perspective was one of health care, or was it really the focus much more on the cost side of the provision of services?

COMMISSIONER LaVECCHIA: I'm going to ask that Assistant--

ASSEMBLYMAN CARABALLO: Sure, absolutely.

COMMISSIONER LaVECCHIA: --Commissioner Bryan to answer because he had more direct conversation with them than I did. But they understood, certainly in the charge, when we sought out consultants to help us, that there were twin goals involved here. It was not simple cost cutting without a mind toward protecting the quality of care for the truly injured so that they would receive appropriate medical care. That's not our attention at all, and I hope this Committee doesn't have that impression because nothing can be further from the truth.

ASSEMBLYMAN CARABALLO: Yes, I'm trying to make sure that's the case.

ASSISTANT COMMISSIONER BRYAN: Yes, just briefly. The consultants from-- The health benefits consultants that we engaged to develop, as is provided by the statute, a set of protocols for the treatment of back and neck injuries -- because we focused on that, frankly, because that's where much of the injury out of automobile accidents occurs and that is the area that is subject to abuse both anecdotally and we've done studies based on information that we had from closed claims and the JUA and the MTF and that sort of thing to confirm that-- So we requested that they develop protocols for the treatment of those injuries while being sensitive to the cost.

Understanding the purpose of the legislation and that that their--

I think their primary focus was to develop an appropriate set of protocols, based on the medical literature, based on their own understanding, that would address sprains and strains of the back and neck and herniated discs, or the development of more serious type of soft-tissue injuries to the back and neck.

And, frankly, in reviewing their work product -- which they put together very promptly at our request and at our need in order to get the rules proposed as promptly as possible-- When we looked at the product and we looked at other kinds of -- other protocols or other standards of care or standards of treatment by the Federal government Department of Health and Human Services, national associations of -- I don't know all of these because I don't deal with them every day -- Academy of Orthopedic Surgeons, and I think even the 1993 chiropractic standards, that they talk about the proper course of treatment for neck and back strains and sprains being in the first 30 to 60 to 90 days -- a conservative course of treatment that involves perhaps some exercises, some evaluation, some medication, perhaps some physical therapy, perhaps some spinal manipulation, those kinds of things.

Depending upon the severity, that would last 30 to 60 to 90 days, and, in fact, most of them are resolved within that period of time. Over 90 percent of them should be resolved within 90 days, 13 weeks, something like that. We found what the consultants provided us was consistent with what other national associations and state associations, too, recommended as the proper course of care for sprains and strains of the neck and back.

We also noted that the care paths also provide for checks to see if something more serious appears to be developing, if there is a deterioration, development of radiculopathy and that sort of thing; then, other kinds of

intervention, perhaps other courses of treatment, are to be considered. Generally for the standard -- and probably no injury is standard, but for the usual type of neck or back strain or sprain in the occasion of having an automobile accident, most of the national authorities that we looked at recommend a conservative course of treatment for 30, 60, 90 days, which is exactly what our care paths talk about.

ASSEMBLYMAN CARABALLO: And Pricewaterhouse was the one -- through the Chair -- was the entity that suggested these protocols?

ASSISTANT COMMISSIONER BRYAN: Yes, yes.

ASSEMBLYMAN CARABALLO: Are they also the ones that reached the conclusion that there are certain treatments or diagnosis or tests that have little or no value in treatment?

ASSISTANT COMMISSIONER BRYAN: No, that was based on--

ASSEMBLYMAN CARABALLO: Is that somebody else?

ASSISTANT COMMISSIONER BRYAN: No, the sections of the rule based on the diagnostic tests-- The list of tests that are not compensable, or would not be compensable, under PIP and the list of tests that will be compensable but under limited kinds of circumstances who are subject to an evaluation of determination of medical necessity -- that was based on a memorandum that was developed by a task group of the professional boards, as the statute provided, that provided us with recommendations. We had our consultants take a look at that -- their recommendations. But, in fact, we found that they were-- Our consultants agreed with that recommendation that, yes, that's reasonable -- that was reasonable, and so we included that in our rules.

I understand that the professional board or some of them -- the Board of Medical Examiners, the Dental Board, and I believe the physical therapists have provided -- the specific boards for each one of those -- have proposed rules, were published in Monday's *Register* -- October 19th, a week ago Monday -- October 19th *Register*, and that are similar, although not exact, and we'll be working with them to kind of reconcile.

ASSEMBLYMAN CARABALLO: Commissioner, one last question. Commissioner, you indicated in your testimony that you are making some changes with respect to the care paths 1, 3, and 5.

COMMISSIONER LaVECCHIA: That's correct.

ASSEMBLYMAN CARABALLO: When are we going to get those changes?

COMMISSIONER LaVECCHIA: Those changes will be ready when we are proceeding to adoption. We still need to finish the public hearing and finish going through the remainder of the comments. So I anticipate going forward with adoption in November.

ASSEMBLYMAN CARABALLO: And those will be simultaneous with adoption?

COMMISSIONER LaVECCHIA: Yes, to the extent that we think all of these are clarification of the rules. There should be no difficulty with making these changes with the adoption filing document at the Office of Administrative Law.

ASSEMBLYMAN CARABALLO: Thank you.

ASSEMBLYMAN DiGAETANO: Commissioner, just one last item, if you will, a point of clarification maybe on your testimony. I did recall

that you indicated in response to my question that the Board of Chiropractic and the Board of Medical Examiners are now in the dialogue with the Department on these proposed regulations. Do you anticipate that prior to adoption of these regs, that those boards will have an opportunity to -- as a board -- pass on these regulations, if you will, as they have on the diagnostic testing?

COMMISSIONER LaVECCHIA: They have already had several public meetings since these rules were proposed, and I suspect, and am led to believe, that there has been discussion among the board. Whether they will take any vote is up to that board, but they certainly have ample time to do so. I believe it's the leadership of those boards that are coming to the meeting with me. And, as I said, I believe the Chiropractic Board meeting is Thursday.

ASSEMBLYMAN DiGAETANO: Thank you very much, Commissioner.

We understand that your schedule requires you to leave us and that the remaining representatives of the Department will continue to be here and be available, is that correct?

COMMISSIONER LaVECCHIA: Yes, and thank you very much for accommodating my schedule. I do apologize to the Subcommittee. I would prefer to be able to be here throughout the hearing.

ASSEMBLYMAN DiGAETANO: We understand, Commissioner.

Ladies and gentlemen, for your edification, we have approximately 45 witnesses signed up to testify. We are going to ask, in the interest of time and the interest of brevity, that each witness coming forward confine your testimony to five minutes or less. That is going to require you to make your

points very succinctly. If you have examples to present, you will have to present those examples within that five-minute period. If anyone here is doing the math, you will quickly realize that if this Committee is to close its business today at 5:30, it is not possible with five minutes per witness to reach 45 or more witnesses.

I will repeat again. If you have written testimony prepared for this Committee, we will be happy to receive that. In addition, we will be happy to have you give a synopsis of your testimony and any specific examples that you may have when you come forward, if we reach you within the prescribed time today. Let me just assure you again that if time does not permit today, and it may not, those who wish to testify before this Committee will be afforded an opportunity at a later date. We do not have a subsequent date, but obviously, the clock is ticking for the 15 percent reduction, and we intend to do everything possible on the legislative side to make sure we meet those deadlines.

So, once again, let me repeat that the witnesses will have five minutes to present their testimony. I will give the first few witnesses the benefit of knowing the order so that those of you who I call and those of you who I haven't called, should the need arise to leave the room, will feel comfortable in doing so. We will hear in the following order.

We will hear Dr. Ratner, First Vice-President (*sic*), New Jersey Medical Society; followed by Dr. Robert Krotenberg, from the Kessler Institute; joined by Nina Geier and Theresa Edelstein, of New Jersey Hospital Association and JFK Johnson Rehab.

We will then hear from Dr. Lomazow, Neurological Society of New Jersey; followed by Dr. Klemons, New Jersey Representative of American Alliance of Temporal Disorders.

I read those names only to give you the first few names. This does not give you the limit of the list. As I said, there are 45 or more who are signed up to testify.

So without any further ado, is Dr. Ratner from the New Jersey Medical Society here? (no response)

Is Dr. Ratner out in the hallway?

UNIDENTIFIED SPEAKER FROM AUDIENCE: He's right here.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Mr. Chairman, that name again, please.

ASSEMBLYMAN DiGAETANO: Dr. Ratner of New Jersey Medical Society.

I'm sorry. He's here, Trooper.

Please take a seat.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Mr. Chairman, excuse me. Just so you know, there is a lot of witnesses who are on the list that are outside. They are all inquiring as to where they are on the list, and so on, and so forth. I don't know if we can do it in a roll call-type fashion or not, but I will call the names out if you want to give them to me.

ASSEMBLYMAN DiGAETANO: Well, I will just repeat those first few. Actually, I will give them to you, and you could call them off outside if you wish.

Do you want to come forward here, Trooper? Thank you.

Good afternoon, Dr. Ratner.

IRVING P. RATNER, M.D.: Good afternoon, sir.

ASSEMBLYMAN DiGAETANO: I don't know if you heard my instructions to those presenting testimony here today, Doctor. We are going to ask that the witnesses confine their testimony to five minutes. If you have written testimony, we would be happy to receive that and please give us a synopsis of it. If you have any specific examples, we ask you to do that within the five-minute time limit. And at five minutes I would ask to sum up if you haven't. I understand that five minutes is not a very long time, Doctor. Please.

DR. RATNER: Can you hear me with this speaker?

ASSEMBLYMAN DiGAETANO: Is the red light on, Doctor.

DR. RATNER: The red light is on now.

ASSEMBLYMAN DiGAETANO: Now I can hear you.

DR. RATNER: Thank you very much.

Good afternoon, ladies and gentlemen. My name is Irving Ratner. I am the President-elect of the Medical Society of New Jersey. I apologize for being late this afternoon. My surgery took a lot longer than I expected, and I came as soon as I could.

I am here on behalf of the Medical Society of New Jersey and its physicians. I'd like to express my appreciation for the ability to be here to speak to you today. There are very few issues which are as important to the people of New Jersey as the constellation of concerns involving access to comprehensive health care by accident victims and the problem with high-priced accident automobile insurance. Physicians are affected as well by this

problem in our ability to meet our patients' needs efficiently and compassionately; and our keen interest in avoiding excessive administrative hassles and cookbook medicine, which we all recognize is not good for patients; and as, of course, in our own role as consumers of insurance in the State of New Jersey. And we agree with the work that is being done with the Governor's work, with the legislative work that is being done, that costs must come down, and access to care must be preserved.

Let me summarize our physician community's concerns. Physicians like myself, who are orthopedic surgeons, as well as neurologists, radiologists, internists, family physicians, all are concerned and fear that medical protocols, or care paths, in the proposed regulations may be overinterpreted by nonmedical personnel, clerks, and nonphysicians who are hired to enforce these protocols.

The staff of the Banking and Insurance Department have performed a valuable service, under recognizably short time frames, in developing these proposed regulations and protocols. But so far insufficient effort appears to have gone into safeguarding accident victims' rights to comprehensive, compassionate care.

We recognize that most citizens in this state, the vast majority, are honest, law-abiding citizens who would not like to undergo unnecessary, painful tests, which sometimes are hazardous, and they would like to get directly to the root of their problem and get well as fast as they can. We in the medical community want for our patients, your constituents and the insurance companies' customers, to have access to medically appropriate diagnostic tests

and services and timely medical treatment that meets the highest standards of quality care, which is the backbone of our medical societies' policies.

We expect these protocols, or care paths, to serve as guidelines. We do not want them to devolve into rigid rules or prescriptions for cookbook medicine. It must be understood, and I think that all of you do understand, that people vary in their responses to trauma, they vary in their responses to medication and other treatments, they have comorbid problems which vary from person to person, and preexisting medical conditions.

We know that you understand this, that the Department understands it, and the insurance companies understand it. What we need then are protocols which will be applied in a flexible and reasonable manner, consistent with good, high-quality medical practice and with an awareness that what works for one patient may not work for another.

We have appended to this statement two reports which were written by our President, Dr. Sachs, and forwarded to the Department previously, and we anticipate that you will be able to work with those and work with us in forming the proper pathways for the medical care. We hope that our support can be used to develop a system which will strike the right balance between efficiency and compassion for our patients.

I thank you very much for listening to me. The Medical Society is very much anxious and prepared to work with you to develop flexible guidelines within which we can live and practice good medicine for our patients. I am available for questions if there are any. And thank you very much.

ASSEMBLYMAN DiGAETANO: Dr. Ratner, your patients are very well served if your surgery is as precise as the time on your testimony.
(laughter)

DR. RATNER: Thank you, sir.

ASSEMBLYMAN DiGAETANO: We thank you for that.
Are there any questions from the Committee members? (no response)

Thank you very much, Dr. Ratner.

DR. RATNER: Thank you very much, sir.

ASSEMBLYMAN DiGAETANO: Dr. Robert Krotenberg, Kessler Institute.

ROBERT KROTENBERG, M.D.: Good afternoon.

ASSEMBLYMAN DiGAETANO: Doctor, are you to be joined by Theresa Edelstein and Nina Geier as well, as part of your group?

DR. KROTENBERG: I think they will be speaking separately.
No, okay. Sure join me.

ASSEMBLYMAN DiGAETANO: Nina Geier and Theresa Edelstein, New Jersey Hospital Association, JFK Rehab and Kessler, respectively.

DR. KROTENBERG: Thank you. Good afternoon, my name is Dr. Robert Krotenberg. I am the Senior Medical Officer at the Kessler Institute for Rehabilitation and the Director of Kessler's Pain Management Program. Kessler, as you may know, is one of the largest providers of physical rehabilitation services in the state. I am testifying before you today because I believe that some of the rules proposed in the Automobile Insurance Cost

Reduction Act would have a negative impact on the patients that are served in rehabilitation hospitals and other postacute settings. There are three specific areas of concerns that I would like to highlight to you today.

First, I applaud the Department of Banking and Insurance for their insight in providing medical coverage for individuals who have suffered catastrophic injuries in the automobile accident even if they have the very basic policy proposed. However, I am very concerned with the language used to describe this coverage. The proposal states that the basic policy provides all medically necessary treatment in the trauma or acute care setting for permanent or significant brain injury, spinal cord injury, or disfigurement in an amount up to \$250,000, until such time that the attending physician deems the patient is medically stable and can be safely discharged to another health-care facility.

I am extremely concerned that the medical necessary rehabilitation would not be covered in this scenario and that insurers would be denying these severely disabled individuals life-enhancing medical care. I do not believe that the Department truly meant to limit the setting in which the care is provided. The proposed rule excludes coverage in nonacute settings for those suffering other permanent or significant injuries, such as multiple trauma. I believe this coverage should also be extended to include rehabilitation hospitals and other postacute settings.

Secondly, although I am fundamentally opposed to regulating medical protocols as proposed in this Act, I do support limiting diagnostic tests, such as surface electromyography and thermography, which are costly, have no scientific basis for their use, provide no use of clinical information

with respect to clinical management. In clinical practice, care paths are guidelines for care, not dictates of care. Patients are all individuals, and as such, their care and recovery will differ according to their specific needs. I am afraid that this type of legislation will interfere with the practice of medicine and a physician's best judgment as to how to render care to his or her patients. These regulations should only make reference to care path as guidelines, not as a set of treatment requirements.

Lastly, I have a major concern regarding the recommendations for medication usage. The omission of using pure agonist and opioids in the treatment protocol for acute pain was either an oversight or a result of recommendations by a physician who has no training in pain management. Not being able to use pure agonist is a deviation in standard of medical care for which many physicians trained in this area would find totally unacceptable and a major step backward with respect to the recent scientific advances made in the specialty area of pain management.

Thank you for your attention.

ASSEMBLYMAN DiGAETANO: Doctor, just for the Committee's edification, you addressed the term pure agonist. Is there a more commonly known to the public term for that?

DR. KROTENBERG: These are basically narcotics, commonly referred to opioids, that are of such a nature that the physician would be able to titrate the dosage to get an adequate pain response. In the current regulations, the medications-- There is a limited group of medications, and many of them are a mixture of Tylenol. The simpler thing would be something like Tylenol and codeine. Well, the amount of fixed preparation you can give to a patient

is limited by the amount of Tylenol. You can't give somebody more than six to eight grams of Tylenol because it can cause irreversible liver damage. So in writing these regulations, if somebody needed a little bit more medication because their pain was not being controlled, the current listing of medications would not provide adequate pain control by virtue of the fact that there is a maximum dosage that you can give a patient. By using a purer, simplified agent you could achieve pain control. And it's really up to the doctor to determine how much medication a patient needs. So that's my area of concern.

ASSEMBLYMAN DiGAETANO: Thank you, Doctor.

Any questions of the Committee? (no response)

Okay, who is next, Nina or Theresa?

N I N A G E I E R: Good afternoon. Thank you for the opportunity to respond to the proposed rules regarding implementation of the Auto Insurance Cost Reduction Act. My name is Nina Geier, and I am the Director of the Brain Trauma Unit/Center for Head Injuries at the JFK Johnson Rehabilitation Institute in Edison. I am also a physical therapist by clinical training and have been involved as a provider of care for patients who have been injured in motor vehicle accidents for many years.

I have seen firsthand how people are affected by injuries sustained in accidents in the full range of possibilities, including the catastrophic injuries seen on the Brain Trauma Unit through other injuries like spinal cord injuries, soft-tissue injuries, traumatic amputations, fractures, and other multiple traumas. I also see how the provision of quality health care that is accessed in

a timely manner can positively impact the outcome and extent of recovery from such injuries.

In New Jersey, we are fortunate to have a well-developed trauma system, quality acute care hospitals, and excellent rehabilitation centers. At JFK Johnson Rehab Institute alone, we literally treat tens of thousands of patients each year. In the area of brain injury, we have one of the largest programs on the East Coast, currently treating approximately 300 patients with a diagnosis of brain injury.

We are actively involved and have supported all legislation that allows for a person's ability to access necessary health-care services and have applauded efforts to eliminate unnecessary treatment. It's imperative that any legislation continues to support the insured person's ability to access quality health care. And I was happy to hear the Commissioner endorse that type of philosophy.

In particular, we applaud the efforts that the legislators have invested in the process of auto insurance reform to ensure the consumers' ability to receive appropriate health care within the provisions of their policies. We have attended several of the public sessions regarding reform where we listened to not only the content, but also heard the intent of the legislation and proposals.

I am here today to ask that some of the language in the proposal be reviewed again so that the intent of the legislation will be clear and so that the consumers' ability to receive appropriate health care will not be compromised simply because of the ambiguities that may exist in the document. It would be a waste of all of our efforts that have gone on for a long

period of time if the bill is subject to misinterpretation by the payers resulting in inappropriate delays in the provision of care or denial of intended benefits.

Our request is that several specific areas of the document be reviewed to ensure that the intent of the legislation is carried out. And I'll give just a few brief examples.

There was an attempt that both the standard and basic policies provide medically necessary health care and from the dollar amount limits chosen for consumers but would not restrict the setting in which medical or health care would be provided. I ask again that the document be reviewed so that all care settings, including inpatient and outpatient rehabilitation services and long-term care centers, be considered and clearly stated in the language of the document.

Also, the term disfigurement needs to be clarified so that misinterpretations can be avoided. Disfigurement should include facial disfigurement, amputation, paralysis, or significant loss of function.

In several areas of the document, health-care provider is used as a term. We ask that this language be expanded to include persons licensed, certified, or otherwise eligible to perform health care. This would allow traditional members of the treatment team that are currently practicing to continue their practice in this regard.

The intent of the basic policy appear to be to offer low-cost choice to the consumer with some significant restrictions related to the PIP coverage but also to comprehensive and collision. It appears that there were some changes in language, and I ask again that this be reviewed.

Clarification is required regarding reimbursement for nonmedical expenses that are prescribed for brain, spinal cord, or disfiguring injuries. Expenses for nonmedical items need to be available to patients with other diagnoses as well. And it is not clear to me why those other diagnoses don't have this provision in the language. I also share the concern about the sections on diagnostic tests and the use of medical protocols as described by--

ASSEMBLYMAN DiGAETANO: Thank you very much.

Theresa Edelstein.

THERESA L. EDELSTEIN: Yes, good afternoon. My name is Theresa Edelstein. I am the Director of Continuing Care Services at the New Jersey Hospital Association. As you know, we represent approximately 115 health-care providers throughout the state, and about 13 of them are comprehensive rehabilitation providers. I am testifying before you today because we believe that some of the proposed rules will have a negative impact on our hospitals.

First, I would like to say we applaud the Department of Banking and Insurance for developing a comprehensive set of proposed regulations within so short a period of time. The Department has met the challenge of preparing a regulatory basis for implementing this legislation. Having said that, I would like to raise two points that my colleagues have not raised at this point and speak in support and echo what they have said thus far.

Just to expand on the concern Nina raised regarding the basic policy. The proposed regulations allow an option for comprehensive and collision coverage in what is labeled the basic policy. This choice of coverage was not detailed in the statute and for good reason. During the legislative

debate on this issue, it was resolved that the intent of a basic policy was to encourage the purchase of insurance by those who economically cannot afford higher levels of coverage. The inclusion of comprehensive and collision coverage changes this intent by making the basic policy more appealing for those who can afford higher coverage.

NJHA believes that this enhancement to the basic policy will undermine the original intent of the legislation, and we recommend that the option for comprehensive and collision coverage be deleted under the basic policy.

The second additional point I'd like to raise has to do with the dispute resolution process proposed. We believe that it is vital to include explicit language to establish a timetable of 30 days for resolution of disputes, with exceptions when deemed appropriate, and to allow providers direct access to the dispute resolution procedure.

Thank you for your attention.

ASSEMBLYMAN DiGAETANO: Thank you very much.

Any questions from the Committee of any one of these three witnesses? (no response)

Thank you very much.

Next we will hear from Dr. Lomazow from the Neurological Society of New Jersey.

Good afternoon.

S T E V E N M. L O M A Z O W, M.D.: Good afternoon. Is my microphone active? (affirmative response)

Mr. Majority Leader and members of the Committee, my name is Dr. Steven Lomazow. I am a neurologist and Chairman of the Protocol Committee of the Neurological Association of New Jersey. I am here today to inform you that it is the opinion of our association of the protocols for testing and treatment of automobile accident-related injuries recently published are inadequate, poorly prepared, and provide nowhere near an acceptable standard of care necessary for the proper treatment of the citizens of this state.

I don't have to tell you how the rules were promulgated. The testing I can clarify for you considerably. The testing was put together by an ad hoc committee of professional boards, including Dr. Gregory Rokosz, who is the Vice-President of the State Board of Medical Examiners, in conjunction with a chiropractor, a physical therapist, a clinical psychologist, and a dentist. One representative from each board promulgated all of the testing regulations. We find the regulations to have gross and glaring inadequacies.

The Neurological Association formed an ad hoc committee of six expert physicians, of which I am chairman. With considerable effort based on sound scientific documentation, utilizing learned treatises, a detailed set of protocols was devised. They are in accordance with the spirit of the legislative act, and our opinion would bring about significant reductions in the cost of medical care without significantly compromising the quality of medical care. We recognize and applaud Dr. Rokosz in representing the medical profession in the promulgation of a set of testing protocols but feel that the extensive input of an expert panel of specialists using materials not available to Dr. Rokosz should supersede the present proposals.

The Neurological Association is also concerned that the medical testing here has been determined by some individuals with absolutely no expertise in the field of medicine. We would not undertake to regulate the field of dentistry, physical therapy, chiropractic, and clinical psychology, and, accordingly, do not wish to have our profession regulated by individuals of those disciplines.

With respect to the treatment protocols, they were put together by Pricewaterhouse Coopers, who are contracted by the Department of Insurance. They hire their own panel of physicians. They identified a long list of diagnoses but only commented on a few, soft-tissue and radicular injuries of the spine. We have reviewed the proposed protocols and care paths and found them to be grossly insufficient and unscientific. The panel physicians they have employed have no background in clinical medicine. Only one of them has ever practiced clinical medicine, and most of them have backgrounds in managed care. None of the members of the panel are from New Jersey. In fact, they specifically cite a board-certified physiatrist, Dr. Andrew Brown, as their principal consultant, who they allegedly received his input through an “informal telephone conversation.”

Well, we contacted Dr. Brown. A letter of Dr. Brown to Mr. Bryan is appended to this testimony. He states, “At no time did I authorize the use of my name as a contributor to this document. Having reviewed the executive summary, I strongly disagree with their conclusions and protocol.” Aside from the obvious misstatement of Dr. Brown’s opinions, we do not feel that information gathered by informal telephone conversations should be the

basis for the treatment of thousands of New Jersey citizens. This demonstrates the overall incompetence and lack of credibility of PwC's methodology.

We looked at their reference list. They cited the American Academy of Physical Medicine and Rehabilitation Practice Guidelines and Outcomes. We contacted the American Academy of Physical Medicine. That reference does not exist. They sent a letter to the State Board, to Mr. Bryan protesting the use of their name in promulgating these protocols. The only article cited authored by an American was by Michael Freeman, an epidemiologist practicing in Oregon. He stated to us in a letter to Mr. Bryan, "In short" -- this is their own consultant -- "these guidelines consist of junk science and baseless opinions. The Department of Banking and Insurance of New Jersey in good conscience could not do other than to ignore these protocols and set about seeking expert help in developing a legitimate set of guidelines."

In a letter to Mr. Donald Bryan, Dr. Ratner has spoke about the Medical Society's position. We agree with their conclusion that they respectfully request the Department delay implementation of these protocols while panels of New Jersey expert physicians and commissions review them and design modifications. There is no urgent need to implement these particular protocols while others are designed through a process that we trust will be more collegial and open.

ASSEMBLYMAN DiGAETANO: Doctor, can you wrap it up, please.

DR. LOMAZOW: Surely.

ASSEMBLYMAN DiGAETANO: Thanks.

DR. LOMAZOW: The bottom line is that we feel that one would not want to build a house using a highly defective set of plans, nor execute a contract without a sound legal basis. These medical protocols are dangerous blueprints for a medical catastrophe to be promulgated on the accident victims of the State of New Jersey. We highly concur with the Legislature that a set of protocols needs to be devised. We have every confidence that the goal of significantly reducing the cost of medical care can be achieved by eliminating unnecessary diagnostic testing and the use of carefully prepared, scientifically based protocols devised by New Jersey physicians to be used as guidelines in the proposed program of medical review and dispute resolution.

Thank you.

ASSEMBLYMAN DiGAETANO: Thank you, Doctor. I for one, as Chairman of the Committee-- (interrupted by applause)

I asked before that you don't do that, folks.

I for one, as Chair of this Committee, Doctor, am extremely concerned about the representations you have made in your testimony with respect to the input of other professionals. It apparently has caused them to contact the Department directly. And I invite continued input to this Committee from you and those others as well on this issue.

I might suggest if you did not hear the Commissioner's testimony at the beginning of this hearing, she indicated to the Committee that the Board of Medical Examiners, as well as the Board of Chiropractic, are in dialogue with the Department now, specifically on these protocols. And I suggest, and I request, on behalf of this Committee that you and those who you have been in contact with who you mentioned in your testimony continue to convey their

sentiments to the Board of Medical Examiners and the Board of Chiropractic as appropriate for the purpose of appropriately advising the Department.

Any other comments or questions from Committee members?

Assemblyman Stuhltrager.

ASSEMBLYMAN STUHLTRAGER: The only comment I would make is that if the allegations contained in your testimony -- I know you skipped through some things -- are true, I would certainly like to hear from the Department in response to some of the specifics about people who supposedly contributed and now are disavowing their participation, and so forth.

I know we have a departmental representative here, so you don't need to comment now. But I would like to hear from you with respect to some of the things that are contained. If you didn't get one of these-- (referring to papers) I guess you did, right? Well, we will get you one here, and if you could respond I would appreciate it.

ASSEMBLYMAN DiGAETANO: Assemblyman Caraballo.

ASSEMBLYMAN CARABALLO: I just want to echo that. I was reading, rather quickly, through some of the references that Dr. Lomazow made, and I saw specifically the letters that he was referring to, and I really do think that if for no other reason than credibility issues that you do in fact respond. And I for one would like to see those responses.

Thank you.

DR. LOMAZOW: Thank you.

ASSEMBLYMAN DiGAETANO: Thank you very much, Doctor.

Ladies and gentlemen, we will now hear from Dr. Klemons who is a New Jersey Representative of the American Alliance of TMD, Temporal

Disorders. While Dr. Klemons is coming up, let me read off the names of the next five witnesses, and then I will have the Committee Aide go out front and read them as well. Dr. Marc Kahn will be coming up with Dr. Robert Grossman from the New Jersey Orthopedic Group. David Matos, University of Medicine and Dentistry of New Jersey. Dr. Boyd Buser, designee of the President of the American Osteopathic Association, coming up with Dr. Ronald Cohen, President of the New Jersey American Osteopathic Association. Andrew Maciak, New Jersey State P.B.A. Physician's Association. Dr. Gary Goldstein, American College of Surgeons and American Trauma Society.

Good afternoon, Dr. Klemons. I assume you were in the room when I gave my instructions earlier to all witness about the five-minute time line.

I R A K L E M O N S, D.D.S., Ph.D.: Yes.

ASSEMBLYMAN DiGAETANO: Thank you, please begin.

DR. KLEMONS: Thank you. I am here today to tell you that these regulations are dangerous and will increase costs.

ASSEMBLYMAN DiGAETANO: Is your light on, Doctor, please? (referring to PA microphone) The red light must be on for you to be heard.

DR. KLEMONS: I don't see a light.

ASSEMBLYMAN DiGAETANO: Push the button one time.

DR. KLEMONS: Can we start again?

ASSEMBLYMAN DiGAETANO: Push the button one time. Is the light on?

DR. KLEMONS: Yes.

Thank you. I am here today to tell you that these regulations are dangerous and will increase costs. The TMJ is the joint which allows you to speak, eat, swallow, and function normally. I speak today not only for the alliance of TMD organizations, which represents 15,000 members and virtually every professional organization with an interest in TM joint dysfunction, and I am also here as President of the American Board of Head, Neck and Facial Pain.

Our position is supported by 28 medical and dental schools and organizations across the country, including the University of Pennsylvania, University of Michigan, and the professor in charge of teaching TMJ surgery for the past 10 years at UMDNJ. Both the FDA and American Dental Association recognize the effectiveness of the procedures denied by these regulations. The Act requires that the DOBI and licensing boards promulgate regs regarding diagnostic procedures which help determine what is wrong with the patient. The two proposals conflict. Consequently, we will summarize problems which are created by the two regulations combined, either of which will lead to an increase in pain, expense, and even death.

The dental board indicated that it relied on a consultant to develop these regs. This consultant is employed by the insurance industry. Consequently, it is no surprise that he has recommended that tests which objectively assist in diagnosing and proving the presence of injuries not only should be denied, but should be described with language suggesting that they are useless, regardless of the fact that they are so strongly supported through the documentation which you see in front of you.

The regulations allow us initially to take only a history and physical exam, plus one type of X ray, either one which shows the middle of the face clearly with low-quality views of the joints and no views of the rest of the head or an X ray which gives a better view of the joints, but no view whatsoever of the rest of the head or face.

The following is one example of the catastrophic effects of these proposals. Mr. Smith has cancer of the jaw, but has not yet developed symptoms when he has an accident. He develops face pain and is referred for evaluation. Because we are only allowed to take one incomplete X ray or another incomplete X ray, we flip a coin and that day determine we are going to take the one of the TM joint, but it does not show the rest of the head. The patient is treated for a jaw joint problem with accepted diagnostic test procedures. Consequently, the patient is treated for jaw joint problems without the accepted diagnostic tests, and consequently, the cancer cannot possibly be found. After six weeks, the regs allow an MRI of the TM joints but no other X ray. Since the cancer is not in the joints, the MRI is worthless. Since the patient was involved in an auto accident, the auto carrier will not reimburse any other test, thereby, preventing the treating doctor from determining that the condition is really not a result of the accident at all.

Months or years later, Mr. Smith requests authorization for evaluation through his health insurance. Obviously, they are the ones that should be responsible, but they say that since the pain followed a car accident, they won't pay until the cancer becomes very obvious or spreads to his brain or other organs. Everyone is very sorry that Mr. Smith subsequently died after acquiring more surgery, including removal of sections of his face, tongue, and

neck, required more expensive radiation and more chemotherapy than would have been required if the diagnosis was made early on. And everyone wonders why New Jersey is the only state where regulators pass the only regulations in this country which would lead to this fiasco. The cost will be hundreds of thousands, if not millions, of dollars in treatment, malpractice suits, and ultimately loss of life.

Please consider how much worse this will be if it occurs in a child whose face is still developing and what if that child is yours. Neither you nor your children will ever be immune from these scenarios.

A second example of a jaw fracture, which will not be diagnosed at a cost of at least \$100,000, is included in your handout. While these are exceptional situations, if you are the one that has it, it might as well be 100 percent. In addition, other more common errors will occur on a daily basis, thereby, ultimately costing millions of dollars over time.

Here you can see 3000 pages of documentation. (referring to written testimony) The first group includes letters from dental school faculty and others who have written in protest. The second stack includes 1200 pages of documentation published in journals fully supporting the use of these procedures, the procedures which were denied. This stack of thousands of pages is the most important of all. Each page is from a patient whose pain was successfully treated because we were able to properly treat them. Our patients include the families of legislators and others from all walks of life. It includes patients who said they would have killed themselves if not for the successful treatment which we provided.

Letters from people who could not previously go to work, school, sleep, speak, or eat without agonizing pain, as well as from professional singers such as one who previously had to stop singing in the Metropolitan Opera and others who previously had to stop singing in the shower.

ASSEMBLYMAN DiGAETANO: Doctor, can you please sum up.

DR. KLEMONS: Pain takes the joy out of life. In summary, the proposed regulations, although well meant, are extraordinarily dangerous. Not only will they drive medicine back 20 to 70 years, but will cause unnecessary suffering and death and increase cost. Neither the 15,000 members which we represent nor the numerous medical and dental school faculty who have written have seen such erroneous regulations anywhere in this country.

Thank you very much.

ASSEMBLYMAN DiGAETANO: Thank you, Dr. Klemons.

Any questions from members of the Committee? (no response)

Thank you.

Next we will hear from Dr. Marc Kahn and Dr. Robert Grossman, New Jersey Orthopedic Group Board members.

M A R C K A H N, M.D.: I'll be solo. Dr. Robert Grossman is the President of the New Jersey Orthopedic Society. He is presently stuck in the operating room, so I am going to solo it myself. And I thank you for giving me the time.

ASSEMBLYMAN DiGAETANO: Give us your name again, please.

DR. KAHN: Marc Kahn. I'm a board member of the New Jersey Orthopedic Society.

The New Jersey Orthopedic Society feels very similar to what the Medical Society feels. Dr. Ratner spoke earlier, and I want to echo his sentiments. The use of protocols, the way they are put forth here in algorithms, is bad medicine. If there was just one way to treat a patient, protocols would be fine; of course, they wouldn't be necessary either. But there are many different health-care providers who have gone to many different types of schools, and we all have a large overlap of how to treat patients, and there are many different ways to treat patients.

Legislating a protocol to tell a doctor, or health-care provider, how to treat a patient is grossly unfair. It takes the judgment away from the physician. Any type of health-care provider has gone through school to learn how to treat patients and to use their judgment. There are many faults, I feel, with the protocols as well, especially the time at the decision point where a patient may have to wait seven to ten days to get an independent medical evaluation to decide whether they can go on treating. During that time what is the patient to do?

The patient, according to the protocols, can be treated. However, if the decision point is that the patient no longer needs treatment, the doctor who treats the patient cannot be reimbursed, and that is grossly unfair to the health-care provider, as well as the patient. Also, we get into some legal issues when we start using algorithms and protocols. Does this become the standard of care? And if a health-care provider deviates from the standard of care and has a bad result, what are the legal implications? This is something else that is grossly unfair.

The bill itself has many good things in it. However, there are many, many things that need to be refined, redone, or scraped. And the New Jersey Orthopedic Society will work with the Legislature to help reform protocols that are serviceable, if necessary, or even scrap the protocols and start from the beginning.

Thank you for your time, gentlemen.

ASSEMBLYMAN STUHLTRAGER: Thank you.

Any questions?

Do you have testimony, too? (affirmative response)

Give us your name, please.

B A R R Y G L A M O R, D.O.: I'm Dr. Barry Glamor. I'm a board-certified orthopedic surgeon and member of the American Osteopathic Academy of Orthopedics Surgeons.

Dr. Kahn did make some very valid points. I don't have many more to add on top of that. I guess my concerns from the standpoint of patient care, as Dr. Kahn mentioned, is basically taking it out of the care of the physician and attempting to place it in a cookbook fashion, if you will, to quote a term that has been used before. It's not good medicine. No patient can be treated exactly the same as another patient. It tends to make a person who is injured in a motor vehicle accident with the same type injury or complaint as somebody who is injured under other circumstances receive a less favorable and less access to care. That just doesn't seem appropriate.

I think that, in essence, the biggest problem that we face from a practical standpoint in an office today is dealing with the difficulties of getting permission, whether it's a managed health-care program or now taking care of

a PIP patient. If you have office personnel and you need approvals and precertifications, you lose somebody in personnel for 20, 30, 40 minutes at a time going through numerous phone calls, waiting on lines, calls that don't get returned.

The problem is basically, if you are taking care of an acutely injured patient, what are you supposed to do with that patient while you go through this morass of approvals or waiting for decision points? Because the patient is the one who is left hanging out there, and the patient, the injured person, is ultimately the one that suffers. It just does not seem manageable or reasonable that a program of this type would go into effect without some type of infrastructure to support it. There is no way to say in what time frame the insurance companies have to get back to the physicians except under the initial instance. Then you go to decision review personnel, you go to medical review organizations. They say reasonable time, but no time frame is set. There is no specifics to handle that. The physicians certainly don't have the personnel to handle all of the phone calls that will be needed. The insurance companies do not have the personnel to handle all of the phone calls that will be coming in. And how long does a physician wait to hear from the insurance company before he does what his patient needs?

Those are my concerns, thank you.

ASSEMBLYMAN STUHLTRAGER: All right, Doctor, thank you very much.

Dave Matos.

Is that Dr. Matos? (no response)

All right, Dave, University of Medicine and Dentistry.

Thank you for coming.

DAVID A. MATOS JR.: Thank you, Assemblyman Stuhltrager, Assemblyman Caraballo. Good afternoon. I am delighted this afternoon to have the Dean of the School of Osteopathic Medicine of UMDNJ to present our testimony, if that is okay, Mr. Chairman?

ASSEMBLYMAN STUHLTRAGER: That's fine. Sure.

FREDERICK J. HUMPHREY II, D.O.: Thank you very much for the opportunity to comment on the Department of Insurance's proposed rules. As noted, as Dean of one of New Jersey's three medical schools and our state's only School of Osteopathic Medicine, I believe that the proposed rules as written will have an immediate and long-lasting impact not only in the practice of medicine in our state, but may prove to be a threat to the health of many New Jersey accident victims.

To date, our school has graduated over 800 physicians, 58 percent of whom have remained to practice in New Jersey. Our mission is to address New Jersey's need for primary care doctors. In fact, almost 75 percent of our graduate medical students are in primary care medicine. Our curriculum emphasizes development of the sound and analytic -- sound analytical and decision-making skills required to practice medicine in today's complex and highly technical environment.

The regulations the State is proposing are overly prescriptive and serve to negate the millions of State taxpayer dollars invested in training physicians to practice medicine. The State should not characterize complex medical conditions, which vary from patient to patient, and attempt to standardize diagnosis and treatment in such a manner as to result in cookie-

cutter medical treatment, arbitrary limitations on the type of treatment which can be offered or on the number of visits allowed in on the rights of patients and on the responsibility of physicians.

Also, the proposal fails to include osteopath-- As written, fails to include osteopathic manipulative medicine as an acceptable protocol for treating accident victims. Osteopathic physicians, D.O.s, are one of two groups, along with allopathic physicians, or M.D.s, who qualify for unrestricted licenses to practice medicine in surgery anywhere in the United States. Their education mirrors that of M.D.s but also includes mastering the principles and practice of osteopathic manipulative techniques. The D.O. then integrates the latest medical technologies and protocols with manipulative therapy to provide holistic care to each patient based on his or her individual needs. There are references in the proposed regulations to chiropractic manipulation which should be broadened to spinal manipulation so as to make it clear that osteopathic manipulative medicine is available to New Jerseyans, many of whom already have a D.O. as their primary care physician.

Specific language changes addressing these issues have been proposed by Dr. Ronald Esper, President of the American Osteopathic Association, in a letter to the Department of Insurance, and I endorse Dr. Esper's recommendations and have attached a copy of his letter in my written testimony.

At a time when public policy, both in New Jersey and nationally, is moving rapidly towards greater flexibility in choice in health care for physicians and patients, the mandates the State seeks to impose are incongruous. We share the goal of reducing the cost of automobile insurance

in New Jersey. I am certain that we also share the goal of a rapid return to complete health for all motor vehicle accident victims. These goals need not conflict, nor does the State have to resort to extreme restrictions on patient choice and on physician judgment to achieve either goal. I certainly offer the resources of the UMDNJ-School of Osteopathic Medicine to assist you in drafting realistic regulations which would serve as guidelines rather than mandates. Working together, I am certain that we can develop an efficient system that will enhance the rapid return to health, mobility, and productivity of those unfortunate victims of automobile accidents in our state.

Thank you again for the opportunity to testify.

ASSEMBLYMAN STUHLTRAGER: Thank you very much.

Thanks, Dave.

Dr. Boyd Buser and Dr. Ronald Cohen.

BOYD BUSER, D.O.: Good afternoon. My name is Dr. Boyd Buser. I am a practicing osteopathic physician in Kennebunkport, Maine, and faculty member at the University of New England College of Osteopathic Medicine where I teach osteopathic manipulative treatment. I'm board certified in family practice and in osteopathic manipulative medicine. I'm here today at the special request of Dr. Ronald Esper, President of the American Osteopathic Association.

The AOA represents the 40,000 osteopathic physicians practicing throughout the United States. The training and certification of osteopathic physicians, as mentioned by Dean Humphrey, closely resemble the training and certification of allopathic physicians. I am very pleased to hear the

comments from the Commissioner earlier in the day about the anticipated changes which will be more inclusive to osteopathic physicians.

Attached to my written testimony that I provided to the Subcommittee is a study that compares the cost of osteopathic medicine with the cost of other providers in two states in the workmen's comp arena. This evidence suggests that osteopathic medicine is highly cost-effective. And I think it is important to note that these were independent studies, neither commissioned nor conducted by the osteopathic profession.

We share some of the current concerns expressed previously about the methodology used to develop the care paths. Pricewaterhouse Coopers, it seems clear from my review of the care paths, did borrow heavily from the AHCPR guideline on management of acute low-back pain in adults. That was an evidence-based guideline that was developed to give practicing physicians an opportunity to look at the best medical evidence available to be able to use that in the planning of their care and was never intended to dictate care.

The proposed regulation it seems, at least in review of it-- We don't see the flexibility in the procedures and in the care paths that was earlier discussed by the Commissioner. It seems that any deviation from these care paths is going to present a great administrative burden to the practicing physician. To such an extent that I believe that many physicians will decide that they can no longer provide care to patients injured in auto accidents.

I think that ultimately this is going to have a bad effect on the patients and citizens of New Jersey and that you are going to start to hear from them as they see that their physician -- their primary care physician, who is taking care of them for a number of years-- When they present to that

physician with an auto injury and find out that they are -- that their physician whom they trust and with whom they have a relationship is not going to be able to provide them with care because of the administrative burden proposed by these regulations, then I think that that is going to be an unintended consequence of implementing the regulation as proposed.

We're certainly not here to defend any abuse of the system. In fact, the AOA is very much interested in providing any assistance possible to improve the quality of health care that it being delivered while reducing the cost. And with that I will conclude my testimony and respond to any questions you might have.

ASSEMBLYMAN STUHLTRAGER: Dr. Cohen, I think you have a little challenge summarizing your testimony that I flipped through here.

R O N A L D C O H E N, D.O.: It's awesome.

First of all, I would to also say thank you. I'm about as far removed from motor vehicle as one can be except for driving to and from work. I'm a cardiologist practicing in the southern part of the state but serve as the President of the New Jersey State Osteopathic Association, and clearly this has been an educational process for me.

I would just like to state that we at the New Jersey State Osteopathic Association do commend the efforts to reduce the cost of automobile insurance, and we, too, want to work with the Committee with regards to developing protocols that are reasonable. I do want to personally thank the Commissioner and the Assistant Commissioner with regards to the technical change of clarifications with regards to osteopathic manipulative therapy in the care paths.

We do have several concerns, and I will state them briefly. One would be the opposition to a care path since a physician cannot practice on a cookbook basis. This has already been brought forth. Care paths, we feel, should be nothing more than guidelines, or framework, for physicians with regards to the treatment of patients. We do have a concern with regard to the interpretation of protocols, and we feel the guidelines and the care paths may well exceed the scope of the legislation.

We also do want to state our concern with the proposed regulations and the potential interference with regards to physician's ability to practice medicine. We also feel a concern that the regulations, as previously stated, are clearly overly administrative and will create significant financial burden to physicians who are trying to practice a good-quality medicine in their office.

Finally, we feel that there is a standard of care established for PIP patients by law. There is a risk for liability with regards to physicians. So having stated that, we do commend the effort. We stand ready to work with the Legislature and the Insurance Commission, and we do thank, again, the Insurance Commissioner and the Assistant Commissioner with regards to the inclusion of osteopathic manipulative therapy, and thank you.

ASSEMBLYMAN DiGAETANO: Pretty good job, Doc.

DR. COHEN: Thank you.

ASSEMBLYMAN DiGAETANO: Any member of the Committee have any questions? (no response)

Thank you very much.

Next we will here from Andy Maciak, New Jersey State P.B.A. Physician's Association.

ANDREW MACIAK, D.C.: Is the red button on?

ASSEMBLYMAN DiGAETANO: If your light is on, you are on, sir.

DR. MACIAK: All right.

Good afternoon, gentlemen. I want to thank you for the opportunity to provide this testimony regarding the proposed rules for personal injury protection benefits. I'm Dr. Andrew Maciak, and I represent the chiropractic division of the New Jersey State P.B.A. Physician's Association. Our association membership consists of 1500-affiliated physicians who are affiliated with several hospitals across the state.

The P.B.A. Physician's Association is in favor of lowering auto insurance premiums, delivering adequate health-care services, and weeding out the unscrupulous practitioners in the health-care profession. However, we feel that the care paths that have been proposed in the regulation will force patients into potentially more invasive and unnecessary form of care, thereby, neglecting the intent of the regulation in the first place, and that is saving dollars on insurance premiums.

In addition, we think the proposed care paths will adversely affect accident victims in the following ways.

1. Compromise the quality of patient care.
2. Increase the potential for malpractice action; and
3. Increase the likelihood of a patient sustaining a permanent injury.

We have several concerns and reservations regarding the proposed rules which we feel have not been adequately explained or addressed. For instance, who will determine the medical necessity for reimbursement? How long would it take to make the determination to go outside the care path, and who will be responsible for making those determinations?

The P.B.A. Physician's Association is interested in knowing what accepted professional standards were used. I have attached a copy of accepted professional standards for whiplash injuries that were developed by Dr. Arthur Kroft of the Spine Research Institute of San Diego. The regulations and accepted professional standards as currently proposed do not coincide with the research that we have provided to you.

The proposed rules states that if notice of the continuing treatment or diagnostic test is not provided to the insurer, then the treatment, if medically necessary, is subject to an additional co-pay of up to 50 percent. We would like to know what makes it subject to the additional co-pay? We believe that the section is vague in its description of the subject to additional co-pay.

In paragraph 14, which states, "Any decision to deny care based on the findings of a physician" -- that is a direct quote -- we would like to know whether this specific language includes chiropractors. In that respect, this has been problematic to our profession in the past, and we respectfully request that the physician be replaced with the New Jersey-licensed health-care provider.

The P.B.A. Physician's Association wants to work with you and the Department of Banking and Insurance to develop appropriate chiropractic protocols that will ensure mandated savings pursuant to the insurance reform

laws while not compromising the quality of patient care. Let me reemphasize that we also would like to assist the weeding out of the unscrupulous practitioners that have contributed to the high cost of auto insurance premiums. The Association is in favor of establishing a medical review organization to engage in the unbiased medical and chiropractic review for disputes concerning the payment of medical expenses and other benefits under PIP coverage. We have already begun to work in setting up an appropriate utilization review system for the chiropractic profession.

We look forward to working with the Legislature and the Department of Banking and Insurance to develop more appropriate and practical protocols than those proposed in the regulation.

Thank you very much for your time.

ASSEMBLYMAN DiGAETANO: Thank you, Doc.

Any questions of Dr. Maciak? (no response)

Thank you.

Dr. Gary Goldstein of the American College of Surgeons and American Trauma Society. And while Dr. Goldstein is coming up, let me read the next five witnesses. Pam Phillips, American Chiropractic Association. Eugene Cianciulli, Insurance Chairman of New Jersey Chiropractic Society. Dr. Richard Klingert, Council of New Jersey Chiropractors. Gary Pomeroy, Chiropractic America; and Michael Goione, Board of Directors, Monmouth County Chiropractic Society.

Dr. Goldstein.

GARY NEIL GOLDSTEIN, M.D.: Thank you.

ASSEMBLYMAN DiGAETANO: Please begin.

DR. GOLDSTEIN: My name is Gary Goldstein. I'm a physician and surgeon and practice in South Jersey. I'm on approximately 25 different national organizations including the American Trauma Society, American College of Physicians, American College of Surgeons and others, usually as a board member or as someone in the ethics committee.

In looking at the-- Oh, and I'm board certified in internal medicine, orthopedic surgery, and plastic surgery.

In looking at the regulations, I find that they are medically wrong and they are dangerous to the citizens of New Jersey. I also think they are logistically unworkable from a bureaucratic standpoint. In addition, there are going to be a lot of hidden costs in the administration of these regulations which have not been addressed.

Some of what I was going to say has already been said by Dr. Ratner, Dr. Klemons, Dr. Lomazow, and others, and I agree. If you look at the simplest care path, a cervical sprain or lumbar sprain -- I think that's number one and number three -- the care paths list five classes of medication that we can use to initiate treatment. Unfortunately, those classes of medication were known 30 years ago and anything subsequent to that has been excluded. The regulations, as they have been promulgated in term of the care paths, are half-baked.

Now, let's go talk about the dangerous parts of them. If you look at the time frame, and I am talking about the cervical disc, thoracic disc, and lumbar disc care paths -- that's one, three, and five, I believe -- you'll see that you get two to four weeks of conservative physical therapy. Then you have a decision path; then, you get another eight to twelve weeks of physical therapy,

and then the patient is either discharged and shunted that way or surgical consult is achieved.

Now, it's been said that in 90 days 90 percent of the people with neck or back pain resolve. By the way, all those statistics are from European literature and nontraumatic conditions. Those are people who just wake up and their neck hurts, not people that are involved in motor vehicle accidents. But let's assume that we accept the standard. For me, to gear up to do surgery at three months, I have to start the surgical process in terms of getting the blood tests, and so forth, at 60 days. So the decision to do surgery is going to be made very, very early. You are going to have a lot of unnecessary surgery because the citizens of New Jersey are going to be strong armed by the rigid following of the care paths. You're going to have people that are going to spinal surgery in 90 days. That's nonsense and that's dangerous.

I'm sorry I'm skipping around. I applaud the idea that we should eliminate medically frivolous tests. However, as these regulations have been proposed, there is a lot of things that are half-baked. For example, the writers of this separate the EMG study from the nerve conduction velocity study. Every textbook I have ever seen says that they are a set of studies that have to be linked together. Unfortunately, you can only do the EMG study once a year and the nerve conduction velocity study, I think, three times a year. It makes no sense. They are half-baked, they are not thought out.

Next, let's talk about the logistics of it. A patient comes to my office and they have anything in the care path. I get one month to initiate treatment. If I want to go on one side of the diagram, I have to call and ask for a decision. How does that happen? First, you send the records. Okay, I've got

to wait for my last dictation to come through. It takes my office about four days to produce a typed dictation. So that comes back. I have to then ask my office staff to copy all the records. We then have to author a cover letter to tell whoever I am addressing what I want to do. And now I've got to mail it to them. Now, that all takes time. Does it take a week? Does it take 10 days? Or do I have to get a computer scanner so I can put it in the computer and send it directly to the insurance company at cost to myself, of course. It is very logistically clumsy.

Now, the medical reviewer reviews the documentation. He has three days to do so. So now we are a week plus three days. And then he issues his decision. If I don't like the decision and say, "We need a physical exam," he has 10 days to set that up. So now we are down three weeks from when I initiated this care path decision. That's bad for the citizens of New Jersey.

Now, let me tell you as someone who does these--

ASSEMBLYMAN DiGAETANO: Doc, I need you to sum up.

DR. GOLDSTEIN: Okay.

What I'm trying to say is the care paths are half-baked. They are not properly thought out. And the problems of the logistics are hidden in the verbiage and will be very apparent when we have to utilize them.

Thank you.

ASSEMBLYMAN DiGAETANO: Thank you, Doc. You did hear the testimony earlier from the Commissioner that there is an ongoing dialogue with the appropriate professional boards. And again we encourage you and your group to maintain a dialogue as well with the Department.

I'm sorry, Assemblyman Caraballo, did you have a question? (no response)

Pam Phillips, American Chiropractic Association from Washington, D.C.

P A M E L A P H I L L I P S: Can I ask that Dr. Cianciulli also join me, who is an ACA delegate?

ASSEMBLYMAN DiGAETANO: Since he was next on the witness list that permission granted.

MS. PHILLIPS: That worked pretty well.

Members of the Committee, my name is Pamela Phillips, and I am Vice-President of Government Relations for the American Chiropractic Association. The ACA is the largest national membership association representing a majority of licensed doctors of chiropractic in the United States.

The steadily rising costs of automobile insurance covering personal injuries and dissatisfaction with the liability-based system for compensating victims have stimulated policy debates in numerous states as yours and also at the Federal level over the last three decades. The ACA recognizes the necessity for automobile insurance reform but has serious concerns with the proposed regulations in New Jersey pertaining to the implementation of the Automobile Insurance Cost Reduction Act.

In issuing these proposed regulations, the Department of Banking and Insurance made assurances that while these reduce personal injury benefits, the regulations maintain quality of care for injured motorists. This is simply not the case. By limiting the amount of chiropractic visits, injured motorists who benefit from effective chiropractic care will experience an

alarming limitation to the treatment that they would typically require to fully recover from injuries following an accident.

I was happy to hear, however, the Insurance Commissioner did mention that there would possibly be an increase. So that should be hopeful, but it still will be a limitation.

The proposed care paths developed by an accounting firm, not health-care professionals, reflect a serious lack of knowledge about the benefits of chiropractic in treating automobile-related injuries. The proposed rule lists certain ICD-9 diagnosis codes which are associated with the various care paths. It should be noted that all codes listed in this section are codes currently utilized by doctors of chiropractic and reimbursed for and by both commercial carriers and Medicare. Automobile injury patients should not be denied the appropriate chiropractic care that many private and Federal insurance programs recognize as covered services.

Not only do these proposed care paths limit patient access to effective chiropractic treatment, but also patients would not have the option of continuing chiropractic treatment unless they pay out of pocket. In addition, after four weeks of treatment, a patient must go through a review process, including a medical examination. If this reevaluation determines that a patient needs additional treatment, chiropractic patients will be required to alter their treatment plan. This takes away the patients' right to select their choice of health-care providers and does not provide for continuity of care.

The ACA is also deeply concerned with the Department's bias toward managed care for treatment of automobile-related injuries. In utilizing this approach, the ACA is convinced that patients will lose their ability to seek

the expert care of a chiropractor. In fact, a 1990 study, which the executive summary is included with my testimony, found that gatekeepers' lack of knowledge about the benefits of chiropractic services greatly reduces a patient's access to a doctor of chiropractic, as a matter of fact, as much as 90 percent. As a licensed, doctoral-level health-care professional, a chiropractor's right and responsibility to serve as a first contact portal of entry must be preserved.

I will skip over the next part. There is also a Federal law that -- I should say a Federal bill -- that was introduced last year. It was not passed, but it has a lot of similarities to what is going on in New Jersey, and I did want to make a couple of points regarding that. I think the biggest problem is going to be anytime that you put limitation on patient treatment you are going to get into some cost shifting. If you have a patient who needs to be treated, you are going to have to go someplace else in terms of getting reimbursement. This could include the State-mandated disability insurance, worker's compensation, Social Security disability, or any similar State program providing disability benefits. In addition, victims of catastrophic accidents will be forced to rely upon taxpayer-funded health-care and welfare programs, such as Medicaid, to pay for medical and rehabilitation expenses and wage loss before no-fault coverage applies.

Specifically, the ACA urges this Committee to recommend reevaluation of the proposed rules to codify the Automobile Insurance Cost Reduction Act regarding the utilization of chiropractic treatment. Chiropractic is a safe, cost-effective procedure which can often eliminate the need for costly surgeries and medication, and accident victims should have access to these services if this is their treatment of choice.

I appreciate the opportunity to testify and would be happy to take any questions. Thank you.

ASSEMBLYMAN DiGAETANO: Thank you. Any questions of Ms. Phillips? (no response)

Dr. Eugene Cianciulli.

EUGENE P. CIANCIULLI, D.C.: Thank you, Mr. Chairman and honorable members of the Committee. Thank you for the opportunity to share with you our concerns regarding the proposed regulations. By way of introduction, my name is Dr. Cianciulli. I am a practicing chiropractor physician in Elizabeth, New Jersey. I am here today representing the New Jersey Chiropractic Society as the Insurance Chairman. I want to enter the record that I am not speaking on behalf of the New Jersey State Board of Examiners.

This regulation was enacted with the intent of reducing both fraud and costs associated with MVA trauma. The NJCS recognizes and has always cooperated with the attainment of these goals since clearly they are in the best interests of the citizens of New Jersey. However, reduction of quality of health-care delivery, removal of treatment options, and denying patient's right of free choice of physician or treatment methods was never the intent of this legislation. All too often under the illusion of auto choice there has been an attempt to create PIP managed care and equate quality care with cost savings. This illusion has continuously been exposed as deceptive of the public's welfare, and the wisdom of the elected officials has correctly been to protect citizens.

In the vein of constructive criticism, the process of creating the treatment protocols was flawed from its inception. The utilization of PwC, an accounting firm to create the treatment parameters, is ill conceived and illogical. A review of PwC's expert panel reveals an appalling lack of clinical knowledge concerning the treatment of MVA injuries. I see no national experts, nor anyone of any significant standing, in the clinical community. Further, it is doubtful that any of these so-called experts are in any active clinical practice or in fact treat or have had any experience in the treatment of MVA-related traumas or similar injuries. Many of their clinical recommendations, if not flawed, are certainly open to serious clinical debate. Some recommendations such as the absence of chiropractic care and spinal manipulation for herniated discs or radicular syndromes are not only irrational, but contrary to the overwhelming scientific literature supporting the primary use of spinal manipulation chiropractic treatment. It should be noted that approximately 94 percent of all spinal manipulation worldwide is performed by chiropractic physicians. To have eliminated D.C.s and substitute a surgical physical therapy model is not only ludicrous, but it's blatantly prejudicial.

While on the issue of PC and the development, because that's been spoken before, the report from PwC discloses their team consisted of three M.D.s, two R.N.s, and a M.B.A. They did say that there were three professional articles authored by three individual doctors of chiropractic, and they represent no one. There was no input from the ACA, the largest organization. There was no input from the Association of Chiropractic Colleges. There was no input from FCER, the Foundation of Education Research, and there was no input from any of the college community. The one

physician that they do quote is writing a paper -- he was involved with Quebec, and he was involved with a report in the Quebec task force study which has since been studied and proven to be flawed in its publication.

When we look at the PwC team, we ask ourselves who in fact were they expert for, and whom in fact did they represent? And from all of the testimony I've heard from my medical colleagues, as well as our testimony from chiropractic colleges, they represent no clinical competency at all.

In the regulation, we have some other serious concerns which I think were never addressed, one of which was the PIP fee schedule, which we've been asking since 1993 to be revised considering the fact that the CPT and therapeutic advances haven't achieved -- that's not been done. Where in the regulation do we address the ongoing problem of benefit assignments and timely reimbursement for medical fees? Surely it is not in the patient's interest for the attending physician to be at risk for reimbursement while the insurance companies deny or delay payment. While the regulation provided for MRO and dispute regulation, should not physicians who perform less than valid independent examinations be subject to reporting the DOI and then, in turn, referred to their proper professional licensing board or directly to that board for review of their clinical competency and adjudicating private cases? The respective boards have jurisdiction over the professional conduct of their licensees.

The professional boards also have dominion over all aspects of the practice of their licenses. They were correctly utilized to determine the protocols of diagnostic testing. Why were they not utilized in the development of treating parameters? They certainly have the resources and the capacity to

consult with whomever they deem necessary to achieve a consensus protocol. As these protocols have been led to believe (*sic*) they have until March of '99 to be established, there is certainly ample time to modify and correct them.

As a member of the ad hoc committee involved with the diagnostic testing, it was ignominiously reaffirmed that all of these guidelines were to be flexible and not clinically rigid. Furthermore, the ultimate decision was to be determined by the clinical judgment, thus, allowing for the variance in treating injured patients.

I'm going to skip over--

ASSEMBLYMAN DiGAETANO: Doc, I need you sum up.

DR. CIANCIULLI: Okay. I'm going to submit to you some submission points, and I just want to speak just two seconds on precertification because I think that's critical.

Precertification provision of the statute, if implemented by the proposed rules, violates the clinical ability of the attending physician. This places both the physician and the patient at serious risk, which we believe was not legislative intent. Also, there are serious concerns about the malpractice issues if we practice, as we've heard the term, cookbook medicine, protocol medicine. I have submitted the testimony from NCMIC, which is the National Mutual Insurance Company of America, the largest chiropractic malpractice carrier worldwide, and we have testimony and a report from their legal counsel showing the serious malpractice and liability risk to physicians who practice in this prescribed way.

I thank you for your time.

ASSEMBLYMAN DiGAETANO: Thank you, Doc.

Any questions? (no response)

Thank you both very much.

Dr. Richard Klingert, Council for New Jersey Chiropractors.

RICHARD M. KLINGERT, D.C.: Thank you, Mr. Chairman and Committee members. My name is Dr. Richard Klingert, and I am Vice-President and Insurance Chairman for the Council of New Jersey Chiropractors. Back in April of 1998 I testified before the Joint Committee on Insurance Reform and presented a document of evidenced-based research and recommendations for cost containment.

I have included in this document for each of you, the Council of New Jersey Chiropractors' positional response to the proposed regulations and our recommendations. The proposed regulations created as a result of the Automobile Insurance Cost Reduction Act contains the recommendations which are not consistent with the chiropractic standards of care, clinical practice guidelines, or the best available clinical and empirical evidence. The proposed regulations do not represent the appropriate operationalization of the statute. Furthermore, they could result in substantial pain, suffering, and costs by denying proper care.

There are five issues that the Council of New Jersey Chiropractors are most concerned about. Subluxation, radiculopathy, treatment protocols, diagnostic tests, decision point review.

First, subluxation. The Department has wrongly removed chiropractic subluxation, which is the clinical condition specifically mentioned in the statute governing chiropractic care. Subluxation, as defined by the Association of Chiropractic Colleges, is a complex of function and/or structural

and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. Also, subluxation is the primary modality permitted by the doctors of chiropractic under the Board of Chiropractic Examiners regulations. The Council recommends that subluxation be specifically included as a clinical condition associated with auto injuries.

Two, radiculopathy. The current proposed elimination of chiropractic care for patients with disc herniations or radiculopathy. The scope of practice of chiropractic in the State of New Jersey, as well as the standard of care in New Jersey, allow for the treatment of herniated discs and radiculopathy in the cervical, thoracic, and lumbar regions. There is ample scientific evidence included in your packet that supports the chiropractic treatment of these conditions.

Three, treatment protocols. The Act states that the boards may enlist the services of a consultant; however, it was the Department, and not the boards, which engaged Pricewaterhouse Coopers concerning the development of medical protocols in the proposed regulations. Furthermore, the Department has accepted Pricewaterhouse Coopers' recommendations which relied on the mercy guidelines, 1993 adopted. These standards were specifically rejected by the State Board of Chiropractic Examiners on October 16, 1997. Please note the Pricewaterhouse Coopers panel developed the care paths set forth in the regulations did not include a chiropractor.

Number four, diagnostic tests. The Chiropractic Board of Examiners is the appropriate vehicle for the promulgation of approved chiropractic tests and not Pricewaterhouse and the Department of Banking and

Insurance. The statutory mandate was to produce a list of valid tests, not a list of invalid tests. Furthermore, the proposed regulations is not consistent with the recommendations of the Board of Chiropractic Examiners, June 18, 1998. The statute mandates that these recommendations utilize standards of the same discipline as the treating provider. This was not done.

What I am concerned about is the Department did not consult any national organization pertaining to chiropractic, nor state organization guidelines. They didn't consult with the standards of care which was adopted by the forum. These standards I will talk briefly in just a couple of minutes.

Number five, the decision point review. The Council feels that the decision point review is not mandated by the Act. The proposed protocols limit the patient to an inadequate trial of chiropractic care so as to force the patient to seek less-effective and often more costly care.

Auto accident trauma cases are complicated injuries. Most health-care guidelines provide protocols for uncomplicated injuries, allowing the treating doctor the latitude of determining medical necessity. The Council recommends that the decision point review procedure be withdrawn or rewritten by the State Board of Chiropractic Examiners. The Council also recommends that the Department withdraw its proposed regulations and include the Forum Guidelines in future regulations so that auto accident patients are not denied the benefits of proper chiropractic care.

I would like to clarify the Chiropractic Forum and who they represent. Chiropractic Forum is an organization within the state which comprises the three state organizations as well as the county organizations. So in essence we're representing maybe a little over 2000 of the 3000 licensed

doctors in the State of New Jersey. The Forum states that the New Jersey Chiropractic Forum is unanimously and unalterable opposed to the protocols of care and the algorithm for care as proposed by the New Jersey Division (*sic*) of Banking and Insurance. Although it is presented as such, the proposal is not representative of any standard of care in chiropractic. We feel that the proposal and algorithm is dangerous, inadequate, and inappropriate for chiropractic care.

I think that was five minutes. (laughter)

ASSEMBLYMAN STUHLTRAGER: Okay.

DR. KLINGERT: Any questions?

ASSEMBLYMAN STUHLTRAGER: No, thank you very much.

DR. KLINGERT: Thank you.

ASSEMBLYMAN STUHLTRAGER: Gary Pomeroy.

GARRISON POMEROY: Good afternoon.

I'd like to start off with, first, I'm not a chiropractor or a health-care professional. I will keep my comments brief, and I would like it to be known that I am speaking on behalf of myself alone. Most of the things that I was going to talk about have already been discussed and will be further discussed. I had some personal thoughts I wanted to share.

I understand the political pressure that was behind the fast-track passage of the 1998 Automobile Cost Reduction Act, the legislation now in question that has caused the legislation to be passed prior to the rules being determined. During the passage of this legislation, it was argued that the rules should be determined and included in this senseless legislation to avoid what we are facing today. Prior to the vote they were not.

Because of the uncertainty of what was to occur during the rule-making process, that, in fact, was pointed out to Mr. Collins and others, it is now clear that the legislative intent is not being met in the rule-making process. Thank you for your attention. Now to correct this.

The Chiropractic Board of Examiners was created to protect the citizens of the State of New Jersey. They, as I understand it, have rejected the proposed care paths based on consumer safety and other reasons. They were required to collectively submit care protocols to the DOBI and did. They voted to submit the Forum Guidelines and supporting documents. In my opinion, they have fulfilled their obligation to the citizens of the state and these good guidelines should be adopted as the rule, not the care paths limiting patients to any specific number of visits that do not take into consideration the following.

1. The doctor's ability to make professional treatment decisions regarding patient care.

2. They allow insurance carriers to interrupt patient care through the use of mandatory decision point reviews in which insurance company-paid doctors pay per review patient care before you can continue appropriate treatment.

3. They eliminate subluxation, which is the large scope of practice for the chiropractic profession, from the list of conditions permitted to be treated.

As a chiropractic patient for many years and part of our state's compulsory automobile insurance system, I find it wrong that in order for drivers in this state to save money or not get rate increases, they must

continually give up important coverage for the care of their choice. I also find it disturbing that the rules do not call for heavier measures to monitor and penalize the insurance carriers for high administrative costs to keep premiums down. If one company can keep costs below 12 percent so should others be able to.

It is also unnerving to see so much emphasis on reduced coverage and so little emphasis on monitoring insurance industry procedures to reduce premiums. These care paths take away a patient's self-determination for care and would leave many frustrated on top of serious-injured fellow citizens. Because insurance is compulsory, we should have the right to choose treatment protocols for ourselves with the help of our chosen doctor. Compulsory insurance -- we are forced to buy it by law -- without satisfactory coverage for chosen care should not be allowed to occur.

It was recently reported that the New Jersey Department of Insurance, Division of Fraud, was given a \$25 million budget for fraud prevention, investigation, and prosecution for 1999. Twenty-five million dollars for one year works out to be just over \$68,000 per day. Perhaps these costs need to be looked at for premium reductions. We, as citizens, should see the report of effectiveness at the expenditure quarterly. We are paying for it.

With all of the above considered, it would seem that the Governor and the Legislature would be more interested in patient care and legal representation to protect the patient right to inform choice, not the insurance company profits.

Administrative cost reduction, fraud prevention, and the monitoring of publishing quarterly insurance company profits should be the

basis of determining policy premiums. It should not be the constant reduction of your constituent's coverage in the event of an accident by your vote.

Thank you very much for your time.

ASSEMBLYMAN DiGAETANO: Thank you, sir.

Any questions? (no response)

Thank you.

Michael Goione, Board of Directors, Monmouth County Chiropractic Society.

While Michael is coming up, we will hear from, following Michael, Linda Tennant, New Jersey Occupational Therapy Association; Dr. Doug Ashendorf, New Jersey Society of Physical Medicine and Rehab; David M. Myers, M.D.; Stanley L. Malkin, M.D.; and Melvin -- hard to read -- Museles, M.D.

MICHAEL W. GOIONE, D.C.: Hi, my name is Dr. Michael Goione, and as a member of the Board of Directors of the Monmouth/Ocean County Chiropractic Society, representing over 400 chiropractors from Monmouth and Ocean counties and the hundreds of thousands of patients we care for, I would like to begin by stating that we joined every state and county chiropractic society in New Jersey in supporting the New Jersey Chiropractic Forum's unanimous opposition to the protocols of care as proposed by the New Jersey Department of Banking and Insurance. We feel that the proposal and care path algorithm is dangerous, inadequate, and inappropriate for patient care.

Me and my colleagues have discussed reasons as to why the care paths are unsafe to patients, take the clinical decision-making process away

from the provider, and in fact, may promote malpractice procedures to take place. I have chosen to discuss the fault of the overall concept of these rules and regulations.

I just want to deviate for one second. I feel care paths and a guideline are two totally different things. A guideline is just what it is, a guideline. As I will try to explain, the care path is a strict way that we must follow.

1. Clinical judgment is taken away from the provider and put into a strategically and intentionally designed system that will allow the insurance carriers to dictate treatment through decision points, IMEs, paper reviews, and precertification. Any concept of the care path removes the ability for provider to make his own clinical judgments as to what he in, in his professional opinion, feels is appropriate for his patient's condition at any given time. I will return to this idea on a complete circle at the conclusion.

2. Care paths. They are the center point of all the proposed rules and regulations regarding treatment. Without care paths, the entire proposal of the Department of Banking and Insurance cannot be enacted and all of the extent of summaries and definitions of these regulations become unnecessary. As I will describe, the proposal and of its nuances are intertwined. It is impossible to remove any portion without the entire concept collapsing. This concept is a premeditated orchestration to remove decision making from the provider and again, as I say, place it into the hands of the insurance carrier through the following definitions.

3. Precertification. Another integral portion of the reform regulations. Precertification pops up all throughout these rules and

regulations. For example, as stated now, any treatment outside of the accepted care path will have to go through a paper review system and be decided by a medical director employed by the insurance carrier. Penalties up to 50 percent co-pays will apply. If, at any point, treatment, tests, or services are deemed medically unnecessary by the insurance company, although clinically indicated, no one is responsible for payment.

Now, this medically necessary definition is defined on -- I have it by Page 18 and I would just like to read this one statement. The treatment is-- The medically necessary means that the treatment is the most appropriate level of service that is in accordance with standards of good practice and standard professional treatment protocols, including the care paths. So what happens is the care path becomes standard for themselves. As defined by these proposed rules the circle is complete. You attempt to get out of the circle and the care paths drive you right back inside. Try to venture out, and as I said, the rules and regulations will force you right back in.

Another aspect of precertification is found on Page 29, subsection *F*, allowing insurers to supply durable medical products directly to their policyholders. However, remember precertification allows the insurance carriers to deny the durable medical product if it is not in the care path, again the circle.

By far what I feel is the most significant subtlety of the precertification is found on Page 7 of the summary and definitions. I am going to quote. "Insurers may, however, offer alternative deductible and co-payment options as part of an approved precertification program, special deductible and co-payment programs." For example, no deductible or a small per visit co-

payment may facilitate use of precertification programs by the consumers. The door is open for managed care regardless of care path. No where in the legislation was the concept of managed care ever approved for introduction into the PIP arena. I do not believe that that was legislative intent, but there it is in black and white.

A few other points. Assignment of benefits. Insurers may file for procedures or restrictions on the assignment of benefits. Even on the last page of the rules and regulations, the insurance carrier is giving a vague go ahead to do whatever they want with the assignment of benefits. Now the provider must also become a collection agent for monies owed. How does this lower health-care cost?

Fraud. New rules and regulations are in place to combat the fraud aspect of PIP treatment in testing. The proposed rules and regulations that are proposed go far beyond-- The proposals and regulation for treatment that are proposed go far beyond what is necessary. Any physician present in this room would applaud the removal of the bad apples. Let the fraud rules take care of the fraud.

Now, with direct modifications of the care paths. Nothing in this document prevents the Department of Banking and Insurance of modifying care paths at any time. After all, they are the standard. This means that if the Department of Banking and Insurance does modify a care path and increase patient visit, for example, they can also decrease them whenever they see fit. Another reason why the care paths are unacceptable.

ASSEMBLYMAN DiGAETANO: I need you to sum up, please.

DR. GOIONE: I'm just about done.

As you can see, the continuation of a care path concept in any form demands the inclusion of all the above mentioned points. The idea that minor modifications can be made to the rules is wrong. The cycle is not complete without all its components intact. For the above reasons, we are unalterably convinced that if the care paths remain in any shape or form so must all the other disastrous regulations. I therefore implore you to instruct the Department of Banking and Insurance to abandon this hoax of treatment protocols and return the clinical decision making to the provider as has been in the past.

I also submit that the Legislative Oversight instruct the Department of Banking and Insurance to go to the respective licensing boards to have them submit treatment guidelines as were originally ordered in the legislation. These guidelines can then be followed, and when deviations from the guidelines is medically necessary, both the insurers and the providers can use the new medical review organization and the dispute resolution system that has been implemented to resolve their differences.

Just one last time. Any concept of the care path, no matter what amount of treatment is included, is unacceptable because care paths ratify the proposed rules and ratify themselves. I have attempted to show the clinical decision process is forever taken out of the doctor's hands and placed into the lap of the insurance industry. So much for patient's rights and freedom of choice. Please reaffirm your original intent of the legislation.

Thank you for your time.

ASSEMBLYMAN DiGAETANO: Thank you very much.

Ladies and gentleman, I read five names of the next five presenters. I will read these additional names. Based on the amount of time we have left, if I do not read your name now, it is unlikely that by 5:30 we will reach you, and this Committee will cease taking testimony today at 5:30. Those names are Michael Marone; Cheryl Kleefeld, Biofeedback Society; Frederick Humphrey; Jessie Rothenberg; Albert Talone, President of Burlington County Osteopathic Society; Russ Bent; and John Caputo.

If I have not read your name, either now or in the five previous, it is extremely unlikely that we will reach you today. If you have signed up and indicated an address when you signed up to testify, you will be called to testify at a subsequent hearing if you choose to do so. If not, again I would repeat that we invite your written testimony to be submitted to the Committee.

Next, Linda Tennant, President of New Jersey Occupational Therapy Association.

GENE MOLROY: Thank you very much, Mr. Chairman.

My name is Gene Molroy, Public Strategies Impact, representing the New Jersey Occupational Therapy Association today. The hour is late so I'm simply going to introduce Linda Tennant, their President, to offer their views on this very important matter.

LINDA TENNANT: Good afternoon. We have passed out copies of it just to-- (referring to written testimony) I'm not going to read it, I'm just going to hit some main points.

My name is Linda Tennant. I am the President of New Jersey Occupational Therapy Association, which represents over 500 occupational therapists in the State of New Jersey. We do applaud the efforts that have

gone into these regulations, but in reviewing them, the New Jersey Occupational Therapy Association does have some specific concerns. Mainly, we are concerned that the proposed care paths do not specify or recognize occupational therapy.

We have attached literature in the exhibits that follow it, which support-- Occupational therapists are currently a critical team member in the event that there is a spinal cord injury following an automobile accident. We feel as though many of the accidents are of people who are working, and we are an intricate part of the team that would help bring someone back into their employment situation.

I'm just skipping along here. Furthermore, it is our experience that as part of a team that it needs to be up to the physician's discretion and the entire team -- treatment protocol in terms of the frequency and the duration regarding specific services.

We have attached our definition of our services, which is actually part of the New Jersey statute. We also notice that there is a description of physical therapy -- that it's included in the summary, and we feel that that should be amended to reflect their current statute definition and also that ours be included as our statute states.

In conclusion, we urge the Legislature to recognize us, to have an opportunity to relook at this, because in general we do not provide treatment and very narrow care paths. We try to look at the individual needs of someone, depending on their specific diagnostic categories, as a member of a team and feel as though people are going to have much prolonged recovery times, the performance outcomes are going to be significantly impeded, and

that in general it is going to be a much more painful and overall long process in terms of recovery.

We will certainly make ourselves available to provide anything and any expertise that we can have-- We do currently have a counsel within the Division of Consumer Affairs.

ASSEMBLYMAN DiGAETANO: Thank you, ma'am.

Are there any questions of Ms. Tennant? (no response)

Thank you very much for your testimony, and, Gene, it was a wise choice to just introduce Linda.

MR. MOLROY: Thank you.

ASSEMBLYMAN DiGAETANO: Dr. Douglas Ashendorf, physiatrist, New Jersey Society of Physical Medicine and Rehabilitation.

DOUGLAS ASHENDORF, M.D.: Thank you very much for allowing me to be here today. I think the biggest challenge at this point is going to be telling you something that you don't already know, but I will try.

I should say my name is Doug Ashendorf. I am a physiatrist. A physiatrist is an individual who is trained to treat disabilities. While I can treat really any disability, whether you break your spine and end up a paraplegic or whether you happen to be in a motor vehicle accident and are in pain-- I can treat any of those disabilities, but I've chosen to narrow my practice to pain management, and this is what I've done for 13 years. I am board certified by the American Board of Physical Medicine and Rehabilitation. And I am also certified by a new board, which is the American Board of Pain Medicine. These are important credentials.

I come here actually today not just as an individual, but wearing actually three hats, and I think you will find each of them a very different perspective. The first hat, and I am honored to be wearing it, is an appointment I received last spring from the Legislature as a member of a new commission which, unfortunately, most people, both the public at large, the Legislature, and the regulatory agencies, know apparently very little about. It's the only explanation as to why I can find that there is such thing as a New Jersey Legislative Commission for the Study of Pain Management Policy which nobody seems to have contacted in the middle of a debate over legislation and policy which regards pain management.

We are a group that was created under the Assembly Concurrent Resolution No. 72 of 1996, specifically for the purpose of studying the "laws and practices of this state relating to acute and chronic pain management by health-care providers." It is the observation of our Commission that motor vehicle accidents, as a source, constitute one of the largest sources of patients with acute and chronic pain in the state. Accordingly, we believe that any policy that affects how this patient population is treated will have an enormous public health impact, both financially and in a humanitarian sense. The Commission has previously expressed in a number of venues its concern about the diagnostic and treatment restrictions as promulgated by the Department of Insurance. Specifically, our concerns are as follows.

1. That restricting-- That the results of these regulations will ultimately restrict legitimate and necessary access to adequate medical care by patients with acute and chronic pain disorders due to vehicular trauma.

Our second concern is that by creating a very regulated medical environment, appropriate pain management, which means leaving the physician to use his clinical judgment and to use state-of-the-art concepts in pain management, will be defeated.

The third concern is that because of the first two concerns that the number of new cases of chronic pain due to an adequate or insufficient or acute pain will soon begin to accumulate.

Our Commission, like everyone else who has been here today, does recognize the need to reduce auto related health-care expenditures due to overuse and fraud. However, it is our belief, very importantly, that while those overuse and fraud issues may save some money, any money so saved will be undermined by the new influx of patients with inadequately treated chronic pain -- acute pain -- which will eventually become chronic pain patients. And, as we know, chronic pain patients actually utilize the greatest number of health-care dollars of all pain patients. We therefore believe that any savings realized through fraud and abuse issues will be undermined as short-term savings later undermined by long-term losses.

It is my individual opinion, and I am not speaking for the Commission at this point, that most of what we are talking about here today is good faith. It is good faith on the part of providers. It is good faith on the part of practitioners. It is good faith on the part of regulatory agencies. Good faith behavior is really what this is all about. If any of us loses credibility in the eyes of the other, I think all of our efforts are in vain and will simply accumulate more controversy and distrust.

I must ask, as a member of the Commission that has 12 experts purely devoted to the study of pain management policy in the State of New Jersey, why the Department of Banking and Insurance, despite two invitations by our chairperson, has so far decided to reach out to, number one, an ad hoc committee of nonexperts from our licensing boards who know very little about pain management issues, and, number two, to reach out to an actuarial firm to inform itself about the issues at hand when a standing legislative commission for the purpose consisting of experts in the field already exists?

ASSEMBLYMAN DiGAETANO: Thank you, Doctor.

DR. ASHENDORF: Am I out of time here?

ASSEMBLYMAN DiGAETANO: Very much so. (laughter)

DR. ASHENDORF: Thank you very much.

ASSEMBLYMAN DiGAETANO: Any questions? (no response)

Thank you.

Dr. David M. Myers.

Sit right down there. Any chair is fine.

DAVID M. MYERS, M.D.: Gentlemen, Committee members, I am just a tired, old soldier, and I am here fighting for my patients. I am board certified in orthopedics, an Associate Professor at Robert Wood Johnson Medical School, and an active orthopedist for the last 25 years treating motor vehicle patients in the inner-city communities. And also today, if this Act is enacted as written, I am also irrelevant to my patients.

Over these years I have been in Trenton too many times. I've testified when no-fault was born, again during monetary threshold debates, again in 1989 regarding the verbal threshold, last summer before Speaker

Collins, a couple of weeks ago with Assistant Commissioner Bryan, and now again today.

I completely understand the genesis of this legislation. I know it is not the New Jersey's Legislature intent to harm patients and their constituents and to rob them of the model PIP benefits that they currently enjoy. The intent was to reduce cost, but this Act will not accomplish that. The Legislature, to their credit, has soundly defeated attempts to have a managed care PIP program. The voting public has made it quite clear that they do not want managed care in any form. They don't want the Legislature involved with their health care, they don't want the government involved, and they certainly don't want the insurance company involved.

I work with some of the best managed care programs in New Jersey, out of Robert Wood Johnson Hospital and my other associations, and even the very best are disaster for the patients. Please believe me, this Act is a backdoor attempt to impose a managed care PIP program for New Jersey motorists. I sincerely disagree with the Insurance Commissioner when she says this is not managed care.

Make no mistake about it. You will have a disastrous managed care PIP program if the Insurance and Banking Commission care paths are instituted. The Act as authored is medically unsound, as you've heard from many people smarter and brighter than myself, and impossible to administer without a delay in treatment and serious harm to patients, and the patients are in fact, of course, your constituents.

You might ask why this is doomed to fail. First, when an accounting firm, Pricewaterhouse Coopers, engaged to develop medical

treatment, care paths, the message is quite clear to us. Your constituents' medical care is less important than the bottom line of the insurers. This approach and the fact that they in fact were the ones that came up with this approach taints all the other conclusions of this Act, the fact of who was selected to make this up.

And what are care paths? Care paths are just boxes to put patients in, and not every patient fits in their box because they have various medical histories and problems. With this Act, if your constituents don't fit in the box when injured, they have to delay in their treatment and/or deny care or punished -- essentially punished -- by an increase in their co-payment or, in fact, no pay at all. If providers have no assurance of being paid for their care, they just aren't going to get it.

In the urban areas where I work, Paterson, Irvington, Brunswick, this means that a large number of patients won't have any access to indicate a medical care after a car accident because they don't have any other insurance.

I want to mention one thing which has been touched on by Dr. Lomazow, and it's a source material used by Pricewaterhouse Coopers to develop these paths, each of which, I might add, I've read. I got the information, and it's very hard to get because it's very obscured to say the least. I just want to touch on the name of the authors and the country they are from. This is the source material for Pricewaterhouse Coopers. Barnsley from Australia--

ASSEMBLYMAN DiGAETANO: Doctor, you might not want to read that because, if you do, I don't think you will be able to finish on time with the--

DR. MYERS: Well, I'll put this in, and I'll take that as my last statement then.

Barnsley of Australia, Koes of the Netherlands, Borchgrivik of Norway, Bylund of Sweden, Jordan of Denmark, Malmivara of Finland, Dick Armev -- I didn't know he was practicing medicine -- the U.S. House of Representatives, and Freeman, a chiropractor, talking about medical care. The medical community of New Jersey and the New Jersey Medical Society were never consulted, as you've heard. Does the State think that we are licenced-- Does the State that we are licensed in consider us chopped liver? If you must have a care path, go to the medical community in New Jersey to assist you in developing and give them time to do it right. And I think that's--

I will cut my presentation short, and I thank you for your time.

ASSEMBLYMAN DiGAETANO: Thank you very much.

Any questions from members of the Committee? (no response)

Thank you, Doc.

Dr. Stanley Malkin, M.D.

S T A N L E Y L. M A L K I N, M.D.: Thank you members of the Committee. I am a board-certified neurologist and Assistant Professor of Neurology at the Mount Sinai School of Medicine. I'm also a Charter Member of the American Society of Neuroimaging and want to speak on neuroimaging, which has not been covered today, which is CT scanning and MRI, which are pivotal tests in the diagnosis and treatment of injured patients.

I established the second CT scanner in New Jersey, the 29th in the United States in 1975, and the second MRI scanner in the state in 1981. I remember the first films from each of these scans, when our technical and

professional and clerical staff were so thrilled, we felt that we were the scientists at NASA in the 1960s. When we got our first images from these scanners that was our walk on the moon.

MRI has eliminated the risk of missing a herniated cervical disc compressing the spinal cord and nerve roots. It's the source of the injured patient's neck pain. Without the knowledge of this very serious problem, a patient can undergo manipulation of the neck or aggressive physical therapy and end up paraplegic because there is a disc pushing on the cord. You can't tell that just from the history of neck pain alone. You can't treat without an appropriate diagnosis.

It's a similar situation in the lower back where patients can have back pain. There is a disc pushing on the nerve fibers going to the bladder and, with a delay in diagnosis, end up with permanent urinary incontinence or permanent loss of sensation or motor function in the lower extremities. The neuroimaging studies are critical to that diagnosis. The neuroimaging has revolutionized the practice of medicine. And the decision to remove these studies from the hands of the physician treating the patient and replacing them by an insurance company nonphysician clerk attempting to substitute unscientific guidelines are geared only to restrict the testing.

The proposed care paths have one goal alone referable to neuroimaging, and that is to withhold care from the patient. They follow a nonscientific attempt to reduce costs regardless of what the cost to the patient may be. These paths clearly place the patient in harm's way by blocking the ability of the treating physician to make the correct diagnosis. He then has to

treat the patient blindly. To use that rock in the moon analogy, we are going back to the days before the *Mercury* capsule.

These care paths are really code words, and they are code words for a path to no care. They should be called no care pathways. I doubt that there is anyone on this panel, or in this Assembly, who hasn't had a family member or friend undergo a CT scan or an MRI that either made the diagnosis or contributed to the diagnosis of their medical problem.

You must remember that that auto accident victims have experienced direct trauma to the neck or back, frequently at high speeds, with great force. They are not the same situation as a patient who wakes up in the morning with a neck ache or a backache because of a bad night's sleep. To provide a check and balance of my own thoughts on this issue, I took it to the American Society of Neuroimaging and have enclosed a letter to them as part of my testimony.

I just want to conclude by reading a few points from that letter. The Society states that "we insist that any guidelines have a firm scientific basis built on improving clinical outcomes, rather than just a need to reduce resource utilization, that guidelines be applicable for multidisciplinary settings, and that they have proper review and approval by a panel of clinical experts in neuroimaging." They stated that "the proposed care paths come up short on every one of these issues." And they summarize by saying that "the proposed New Jersey care paths for auto accident victims do not measure up and should not be instituted as they stand." And again I have enclosed a full letter.

If there are any questions, I would be pleased to entertain them.

ASSEMBLYMAN DiGAETANO: Thank you very much, Doc.
Are there any questions? (no response)
Have a good day.

Next we will hear from Dr. Melvin Museles, Automatic Data Processing-Integrated Medical Solution.

Your handwriting is about as bad as mine so I apologize for the incorrect statement.

MELVIN MUSELES, M.D.: That's all right. Museles (indicates pronunciation) is the name, but that's okay.

I want to thank the Committee for giving us the opportunity to make a little presentation here. You already have my written presentation. I am going to have to cut that back significantly to stay within the five-minute period. I am probably one of the few physicians in the room, maybe the only one, that is in support of the Insurance Department's regulations.

Now we have-- Let me just tell you a little bit about myself. I'm Dr. Melvin Museles. I'm currently the Associate Medical Director of Automatic Date Processing-Integrated Medical Solutions. This company resides in Bethesda, Maryland, but is an affiliate of Automatic Data Processing, which is based in Roseland, New Jersey. I am board certified in a number of specialities, including the American Board of Utilization Review and Quality Assurance.

Can you hear me all right? I guess you can.

ASSEMBLYMAN DiGAETANO: Yes, we do.

DR. MUSELES: I want to make some comments about some of the speakers that have spoken here earlier as far as the subject matter. I'm not

going to go into the cost per claim. I think you all know in New Jersey what the problem is compared to the cost of automobile insurance in the State of New Jersey compared to the other states in this union. We do retrospected reviews on automobile casualty insured for a number of clients all over the country. And we find that the data that was presented earlier was very true.

We feel that the Department of Insurance has made a great effort to come up with something that will indeed cut costs and at the same time insure quality of care. We cannot believe that the Insurance Commissioner and her staff are not here to provide and ensure that the insurers of New Jersey obtain quality care. There has been a lot of critique about the issues, and I just want to mention a few of them.

Obviously, auto casualty insurance is the last vestige of insurance that cost shifting has occurred in this country. Health insurance, as you know, there are over 100 million people in managed care. The program has been defined here as really not true managed care. In true managed care, you have to have enroll of members, you have to have a panel of providers that have been credentialed that you must go to. In this project here, in this proposal here, the patients have total freedom of choice. They can go to any provider they so desire.

I want to talk about the care paths. They are really guidelines. They are not truly locked into anything. If you read the language very carefully, the care paths are just the base from which all of your quality physicians in the State of New Jersey can certainly offer quality of care to their patients. Now, there indeed is an opportunity for the insurer here to install some processes such as the decision points, such as a precertification process,

which will require the practicing physician to call somebody in the insurance company or somebody that's designated by the insurance company. It's is not a clerk. This is a licensed professional physician who is experienced in auto casualty injuries. This particular physician has a vary of consultants. If he doesn't know the answer, he can get the answer right away.

And I recommend to the insurance companies, on the precertification process, that they install a 1-800 number so that the provider can call immediately and get a response immediately from the insurer or the medical director who can indeed authorize the care if indeed it is medically necessary.

All we're saying is unnecessary care should be denied. Now, if that care is denied on the telephone with that particular provider, he has several options. He could appeal directly to the insurance company for a first level of appeal, and he should get a response within 24 or 48 hours. If he appeals through the dispute resolution organization that will be downloaded to the MRO, and I do believe the Insurance Commissioner needs to expedite that process so that the treating provider can get a response very quickly.

I'd like to say something about the lists that have no value. Those are according to national guidelines. We talk about a lot of guidelines that have been created by the various societies in the State of New Jersey. I respect every physician, every chiropractor, every provider that has talked here before. They all have made very good points, but they are not always really on target. Care paths are care paths and that's it. They do not prevent medically necessary care. The doctor has every right to go ahead and call in and get approval for a treatment program that may last four weeks. You can treat a

patient with chiropractic for six weeks. I know the care paths says four treatments-- The Commissioner tells me and the Deputy tells me that that's not what they had in mind, and they will make the appropriate corrections.

ASSEMBLYMAN DiGAETANO: Doc, I need you to sum up.

DR. MUSELES: Okay.

I'm just going to say again that the access to care is totally open. That guidelines are just that. They are guidelines, and they are not locked-in protocols and that every profession that was noted here, that has made a comment here, certainly has some points that are valid, and I do believe the Insurance Commissioner should take some of that under advisement.

Thank you very much.

Any questions?

ASSEMBLYMAN DiGAETANO: Thank you, Admiral.

DR. MUSELES: Right, thank you very much.

ASSEMBLYMAN DiGAETANO: Just let me say a belated birthday last Saturday. I don't know if you heard me earlier, that was my mom's birthday as well.

DR. MUSELES: Well, thank you very much. I appreciate that.

ASSEMBLYMAN DiGAETANO: Between that and the Navy, you're doing okay, and we hope you can join us when the *New Jersey* comes back home.

DR. MUSELES: Okay, thanks very much.

ASSEMBLYMAN DiGAETANO: Have a good day.

DR. MUSELES: I appreciate it.

ASSEMBLYMAN DiGAETANO: Michael Marone, Consolidated Services Group.

Is Michael here? I don't see him.

Cheryl F. Kleefeld, Ph.D., Biofeedback Society of New Jersey.

C H E R Y L F. K L E E F E L D, Ph.D.: Kleefeld.

ASSEMBLYMAN DiGAETANO: Kleefeld. (indicates pronunciation)

DR. KLEEFELD: Yes.

ASSEMBLYMAN DiGAETANO: Thank you very much.

DR. KLEEFELD: Thank you.

Thank you for the opportunity to speak and I--

ASSEMBLYMAN DiGAETANO: Is that switch on, ma'am?
(referring to PA microphone)

DR. KLEEFELD: Thank you for the opportunity to speak, and I would like to keep this as short as I can. I would like to stay under the five minutes.

I am here to discuss the aftermath of automobile accidents that are emotional as well as physical and the care that we take. The Biofeedback profession is kind of a bridge between the emotional and the physical. We practice mind-body medicine. Instead of reading a prepared statement, I've brought a lot of information that I would like to pass on to you. I've made packets for each of you.

I really don't expect you to read all of this because this is a lot of reading. But I would like to just review what is in here. I have letters from the Association for applied Psychophysiology and Biofeedback, which is our

national organization, the Biofeedback Certification Institute of America, and also from William Rosenblatt, who is a past president of our Society, who explained the stand that we take.

The next document is from the National Institute of Health. The National Institute of Health has spent millions upon million of dollars studying post-traumatic stress disorder and chronic pain and the type of care that is more appropriate for these particular circumstances. They recommend biofeedback as a cost-effective viable treatment, sometimes the treatment of choice -- sometimes the treatment of choice even when the problem is physical. So this is included here. This is a document from the National Institute of Health.

There are four documents in here concerning cost-effectiveness of biofeedback training. When people are treated with biofeedback on the average, or on the aggregate, there are fewer hospitalizations, there are fewer doctor visits, the recovery time is usually shorter, and there are lower pharmaceutical bills.

I have a letter from Dr. Edward Blanchard, who is with the University at Albany, State University of New York, who has recently published a book called *After the Crash*, which is the post-traumatic sequela of automobile accidents. This was many years -- a long study in progress. It was funded to the tune of \$1.5 million by the National Institute of Health who felt this was a very worthwhile way to treat people. And I'm wondering if the State of New Jersey would like to go on legislative record denying what the National Institute of Health has concluded to be true.

There are also many papers included with this. I'm not going to review them entirely. There are reviews of studies, the use of biofeedback for chronic pain, for headache, temporo-mandibular joint syndrome, which is something that occurs very often after an automobile accident. Sometimes it can be the only treatment, and it's much less expensive than getting an appliance and surgery and whatever. If it's the first thing that people do, we can keep cost down.

So what I am requesting is that you review this literature, that you include us in the care paths and in the coverage that you offer to people because it is cost-effective and it does help people, and we do get people back to work.

Thank you very much for allowing me to speak.

ASSEMBLYMAN DiGAETANO: Thank you.

Any questions? (no response)

Dr. Frederick J. Humphrey.

DR. KLEEFELD: Can I say one more thing? I brought some of my equipment with me. I thought maybe I'd have a chance to demonstrate. But if you would like to me to come back at any time privately, or some members of my Society, we would be only too happy to demonstrate just so you understand what we do.

ASSEMBLYMAN DiGAETANO: Thank you.

Well, we certainly will not reach all of the witnesses as I stated earlier, so we will have at least another hearing.

Is Dr. Humphrey still here?

UNIDENTIFIED SPEAK FROM AUDIENCE: Mr. Chairman, he has already spoken.

ASSEMBLYMAN DiGAETANO: Thank you very much.

Jess Rothenberg.

Is Jess here?

JESS ROTHENBERG: Gentlemen, thank you for your time. I know that it has been a long day, and I will keep my comments very short.

My office assists 80 medical care providers in the State of New Jersey with the relationships with the insurance companies. Doctors are supposed to treat patients. Under the current system right now, a doctor treats a patient, submits the bill, and then the staff has to spend countless hours dealing with the insurance company. Precertification is a big problem. I will challenge any member to get in touch with Allstate, Liberty Mutual, or State Farm right now within the next 20 or 30 minutes. You are on 20- or 30-minute hold, and you are switched all over the office. They constantly play musical chairs, and you can't get anyone to answer a question, review the proper documents, even to get all of the documents that need to be reviewed medically.

It's dangerous to allow the insurance companies to dictate care. Right now they do not process claims properly, that's why there is so much litigation. If the Legislature would do something to make the insurance companies properly process claims, you would cut down the cost of litigation, and there you would see savings. Right now PIP coverage is a minimal part of the policy. I spend \$6000 on my cars a year in insurance, but the PIP coverage is only about \$200 per policy or less. It's a very small part. But this legislation

will cut half of the medical benefits to three-quarters of the medical benefits. Well, if you take a \$200 PIP out of \$1500 policy, I don't see where cutting three-quarters of medical benefits benefit the consumer at all.

Good claims are systematically denied now only to save corporate dollars, and it's done by peer review or by independent exam. The independent exam is where the patient goes to a doctor for five minutes and the insurance company-paid doctor says, "You don't need any treatment anymore," after an incomplete examination. The paper review is worse. They review incomplete medical documents, never seen the patient, but then they cut the patient off from care and refuse to reimburse the provider.

The care path is even an easier way for the insurance company to deny services. Rather than even going through reviewing these medical records, you have to contact them, and they have decision points where they can just cut care completely. Reasonable and customary is used right now by the order company such as ADP and peer reviews to review all the records and never see the patients. The thousands of denials that are issued every week and every month are the same by the peer review doctors, by the audit companies. They say the same things. They could almost be inputted in the computer and just the names change. I have thousands of peer reviews that you folks can look at and to take a look and see how the insurance companies
n o w a r e d e n y i n g c a r e .

Under the old system the assignment of benefits is key. The assignment of benefits allows the insurance company to pay the provider directly. If the patients get paid directly without an assignment of benefits, I don't think any of these providers are going to treat. You can't get the money

from the patient once they have it. You have to sue the patient, and nobody wants to go through a two-year or even a small claims court action.

Also, the assignment of benefits gives the right of the provider to stand in the patient's shoes if the insurance company doesn't pay and proceed, either in court or arbitration, in order to get paid. Without an assignment of benefit, there will be no standing for anyone to proceed in court. That is not fair.

Under the law now, assignment is granted to medical providers. Some of the insurance companies have tried to say, "Well, it should only be upon death of the patient." That was ruled by judges all across the state to be not right and that benefits are assignable. If you look at any kind of business in the state, benefits are assignable. We assign benefits all the time so that that allows someone who is an interested party to pursue the contractual obligation.

You can't leave it to doctors or patients to pursue the insurance companies in court, they won't be able to do it. They are supposed to be treating the patients, and the patients certainly aren't well-versed enough to fight for their own rights. The assignment issue is very, very important. I think it should not be controlled by the insurance company. I think it should remain the way it is now where-- And the insurance companies say that the reason why they don't want to grant the assignment is because they are prejudice in not getting all the information to defend the claim, and that's untrue. They are still, with the assignment of benefits, entitled to an examination under oath, deposition of the doctor, examination of the patient,

a review of all the records. It's absolutely ridiculous that anybody would think an assignment of benefits allows the providers to just proceed.

ASSEMBLYMAN DiGAETANO: Jess.

MR. ROTHENBERG: Thank you so much for your time.

ASSEMBLYMAN DiGAETANO: Thank you. I appreciate it.

Any questions? (no response)

Dr. Albert Talone, Burlington County Osteopathic Society.

Did I say that correctly?

ALBERT A. TALONE, D.O.: Yes, sir.

ASSEMBLYMAN DiGAETANO: Thank you for your patience.

DR. TALONE: Thank you, Mr. Chairman, and good afternoon.

Good afternoon, Committee members and Deputy Commissioner Bryan.

My name is Albert A. Talone. I am an osteopathic physician practicing in Burlington and Camden counties. My speciality is that of general practice of medicine as a primary care physician. I am board certified. I am a former member of the Board of Medical Examiners in the State of New Jersey and also a former trustee of the University of Medicine and Dentistry New Jersey. I am a clinical associate professor at the University of Medicine and Dentistry of New Jersey. I'm a professor of medicine at the University Health Sciences in Kansas City, Missouri, and assistant professor of University Sciences in Philadelphia, the Philadelphia College of Pharmacy and Science.

I would like to preface the body of my comments today by thanking the Deputy Commissioner, Mr. Bryan, and the Commissioner, LaVecchia, on some of the changes -- proposed changes -- to the current Cost Reduction Act protocols. But this came only after a definitive, monthly

dialogue with myself, Dr. Lomazow, Dr. Myers, Dr. Glamor, as well as members of the State Osteopathic Association. I do commend them for this, and I wish to continue this dialogue in earnest as is also recommended by the Chairman of this Oversight Committee.

My day is a daily strain of medical advocacy for my patients in an HMO care environment. As you have heard, 100 million citizens in our country are HMO patients. In an environment that requires physicians to provide cost care to their enrolled patients and balancing this against the community medical standard, it is a most difficult and distracting process.

I stand before you today after this long hearing with ill-afforded time because of my clinical responsibilities to my patients. President Bush was known to say that government-managed health care would be tantamount to health care as provided by the Internal Revenue Service and the Post Office.

Today we, as physicians, are inundated with corporate-managed health care as provided by accountants and business managers, who are insensitive to our unique position as responsible physicians caring for the sick and injured of this state. After reviewing the Cost Reduction Act motor vehicle bill and the personal injury protocols, I was astonished that our State government would move and mandate the distribution of health care to the injured of our state in a strict, medically insensitive, rigid protocol system of managed, spartanized care that is untested anywhere in the continent of the United States.

These protocols provide for the most draconian care environment for our patients in the State of New Jersey. There is no allowance for a

meaningful deviation from these mandates, unless granted by an insurance clerk or reviewer, certainly, an ugly situation for a doctor.

There is no provision for co-morbid complicated medical care and mental health care for the injured. We have yet to hear from the psychologists. I most intrigued and interested about that. Caring physicians will find themselves betwixt and between medical fraud, medical malpractice if they should abandon or deviate from the protocols or patient care respectively. There is no provision for electronic rapid process of these protocols, precertification, certification, approvals of cares, appropriate billing, payments, or any infrastructure -- electronic or otherwise -- provided by anyone, let alone the insurance company, in a commitment by these institutions.

No, the doctor and his staff will be heavily burdened with paperwork, interruption of care, angry patients -- your constituents, our families -- in a system that will be adversarial to say the least. Honest physicians will find themselves in a hostile environment and heavily burdened in a minefield of medical malpractice, fraud, insensitive insurance companies, burdened staff, frustrated office workers, and angry patients that are injured and unable to return to gainful employment in a timely fashion. The medical community understands your responsibilities here today, as we have all said, in this regard of affordable auto insurance to consumers.

We can and should try to work together in a dialogue that includes honest physicians and care mandates that provide for the most modern medicine for the injured in New Jersey. There is no assurance that these outlined protocols, as presented, and their resultant outcomes will provide for better cost-effective care for New Jersey's citizens. No state in this great union

had dared to tread in this manner. This is indeed a troubling and potentially dangerous plan for our patients who we care for and who are our charge. This is, indeed, a bitter dose of medicine for our physicians, patients, and your constituent families.

The law calls for protocols and much must be done before we proceed with these. Better clarified, permissive, and all inclusive protocols of treatment should be constructed with a community of health-care providers. A sophisticated, electronic company -- excuse me-- A sophisticated electronic infrastructure--

ASSEMBLYMAN DiGAETANO: Doc, I need you to sum up.

DR. TALONE: --support should be provided by the insurance company to physicians in order to process and rapidly monitor the progress of patient care and prompt payment for care rendered. Only in this fashion can we evaluate the care outcomes. We should not rush pell-mell into unfounded protocols of marginalized care. We know that accidents are the primary etiology of medical morbidity in the age population of 50 years or less. This population includes the largest employment pool.

For some of our inner-city and less-fortunate citizens, the only health insurance they have is that as provided by auto insurance. Health-care costs for the injured as denied by the auto insurance carrier will be shifted to other resources for funding. We, as physicians, have already seen denied managed care and hospital costs quietly shifted to the uncompensated health-care fund and charity care fund payments in the past. This indeed is a disturbing practice for the taxpayer who foots the bill, regardless.

Peer group intervention must all be constructed so that--

ASSEMBLYMAN DiGAETANO: Doc.

DR. TALONE: --independent medical opinions guarantee the good care of our citizens, not just honest physicians for overutilization of needed medical services.

Thank you very much, Mr. Chairman.

ASSEMBLYMAN DiGAETANO: Any questions? (no response)

Thank you very much, Doc.

We'll now here from Kevin Frederick, Richard Guttschow, and Edward Olsen. And I think that will take us through the remainder of our time.

KEVIN FREDERICK, ESQ.: Good afternoon.

ASSEMBLYMAN DiGAETANO: Good afternoon.

MR. FREDERICKS: Thank you honorable members of the Assembly for the opportunity to speak here today. My name is Kevin Frederick. I'm here on behalf of State Farm Insurance Companies. I brought with me today Dr. Richard Guttschow and Dr. Edward Olsen, and I've asked them to help the Committee answer the question of whether the protocols are consistent with good medical practice and will allow medical providers to administer medically necessary treatment.

Dr. Edward Olsen is a chiropractor licensed in the State of New Jersey. He has two bachelor degrees in biology, and he received his Doctor of Chiropractic, magna cum laude, from the National College of Chiropractic. For a number of years, he actively practiced chiropractic New Jersey, where approximately 75 percent of his patients were treated for automobile injuries.

He joined State Farm in 1995 where he is responsible for training the company's personnel on the analysis of injury claims.

Dr. Richard Guttschow was granted a chiropractic license by the State of Illinois. Following that, he is a doctor of chiropractic from Palmer College of Chiropractic in Davenport, Illinois. He practiced chiropractic in Illinois before joining State Farm in 1997. The treatment of automobile accident injuries represented about one-third of his practice. His duties with State Farm include research and training regarding medical treatment.

Dr. Guttschow.

RICHARD GUTTSCHOW, D.C.: Good afternoon. I'd like to address a few of the concerns expressed regarding chiropractic care and proposed PIP regulations. The care paths seem to be causing the greatest concern. The term care path simply refers to a recommended course of care based on professionally recognized standards. There appears to be concern that care paths 1, 3, and 5 involving soft-tissue injuries would unfairly restrict the practice of chiropractic.

In the course of my review of the proposed regulations, I undertook a study of scientific literature in nationally recognized peer review journals, as well as published guidelines, pertaining to the general practice of chiropractic. Two of the most significant studies that bear directly on these issues are the Quebec Task Force on Whiplash Associated Disorders and a chiropractic study by Niendo and Halderman (phonetic spelling), who are two well-respected experts on chiropractic care. These studies provide important scientific support for the Department's protocols.

Regarding the care paths inclusion of a specific number of chiropractic manipulations, a study by Niendo and Halderman may help explain the inclusion of this number in the regulations. The authors of this study tracked the care of 2000 consecutive patients at Western State's Chiropractic College. It was found that 1280 of those patients were diagnosed with a strain injury and that the average patient required only 4.4 visits for each episode.

The study is significant because it involves such a large number of patients, especially strain injury patients, and is consistent with the typical symptoms seen in a chiropractic practice or clinical setting. The study was not designed to set a number of chiropractic visits, but its findings are consistent with the conservative therapy portion of the care paths for soft-tissue injuries.

I do not offer the study to suggest that four visits is the absolute right number for all cases. It does, however, support the idea that in an average case four visits is a reasonable expectation. To be sure, individual circumstances will warrant deviations from this when the clinical findings of the chiropractors support it. This is precisely what the regulations envision when they provide that treatments outside of care paths are warranted by reasons of medical necessity.

Concern has been expressed that chiropractic manipulation may not continue after the first four weeks of care for soft-tissue injuries. First of all, it appears to me that this is an incorrect reading of the regulations. As already noted, treatment can deviate from the care path when warranted by medical necessity. Nonetheless, it is noteworthy that the Quebec Task Force found that the average time needed for resolution of whiplash-associated

disorders was 31 days. This is consistent with animal studies which have found that strain sprain injuries heal within four to six weeks. The recommendations of the Task Force support the short-term use of manipulation. Yet strain sprain injuries heal within four to six weeks. The short-term use of manipulation should fit within this time frame.

The guidelines for chiropractic quality assurance and practice perimeters, commonly known as the mercy guidelines, are a published set of practiced guidelines commissioned by the Congress of Chiropractic State Associations. The guidelines indicate that after four weeks of manual procedures, or manipulation, there should be a significant improvement in symptoms or referrals should be considered. The American Chiropractic Association has used the guideline statements within their literature, and it appears to be a commonly accepted statement within the profession.

This is significant because it suggests that under most circumstances the maximum chiropractic benefit will be achieved within this time period. Under most cases, if there has not been significant improvement, referral to another specialty, not continued chiropractic care, is the appropriate course of action.

The final issue I'd like to address is the concern that chiropractic care is left out entirely for care paths 2, 4, and 6 for disc herniations and radiculopathy. Under the conservative therapy block of these paths is the inclusion of up to six office visits to the provider. On Page 16 of the proposed regulations, there is a list of the professionals covered under the definition provider. Number 7 on that list is licensed chiropractors. The only portion of care paths 2, 4, and 6 that chiropractors are excluded are for herniated disc

with moderate to severe radiculopathy. These cases require referral to neurologists or orthopedic surgeon.

Moderate to severe radiculopathy of nerve root dysfunction is considered to be a serious nervous system problem. The mercy guidelines indicate that signs and symptoms of acute and serious neurological involvement, usually due to disc herniations, represent an absolute contra indication to chiropractic manipulation.

Also, a textbook found on most chiropractic college campuses titled *Chiropractic Standards of Practice and Quality of Care*, by Vere, states that cervical, or the neck, disc lesions or herniations can cause severe neurological complications in both the upper and lower extremities. Early recognition of these conditions and immediate referral for neurological decompression is essential to prevent permanent neurological deficits. The exclusion of chiropractic care in this single care path is consistent with accepted guidelines of chiropractic practice.

In conclusion, it is my opinion that the Department has made well-reasoned conclusions within the proposed regulations and care paths. There is scientific support, as well as published guidelines, that underline the decisions made by the Department regarding chiropractic care. I feel the patients of this state will receive the quality care they deserve under these regulations.

EDWARD OLSEN, D.C.: Good afternoon, and thank you for the opportunity to appear today. As Kevin had suggested, I am a licensed chiropractor in New Jersey and have been since 1990. In this time I've had the opportunity to treat many patients, most of which were injured in motor

vehicle accidents and suffered injuries that would have been directly impacted by the proposed care paths.

Additionally, I have reviewed thousands of medical records and analyzed the treatment plans established for patients who suffered injuries in motor vehicle accidents. This experience has afforded me the opportunity and the knowledge needed to conclude that the regulations proposed by the Department of Insurance would allow any provider the ability to appropriately treat their patients. As a chiropractor, I believe that the proposed protocols will not limit access to chiropractic treatment, but rather improve the quality of care offered by the professional. The protocols, with their decision point reviews, will afford a level of protection that will assure your constituents that they are receiving the most appropriate level of service for their condition.

Much of the criticism of the regulations and the associated protocols appear to be based on the misreading of the regulation or misunderstanding of how medical or chiropractic treatment is ordinarily delivered. The suggestion is that the care paths would result in appropriate restrictions on treatment as a result of reliance upon novel or insupportable protocols. Nothing could be further from the truth. First of all, the protocols are supported by peer review journals, and, secondly, the ordinary delivery of care today is consistent with these protocols when not associated with automobile insurance.

The Department of Banking and Insurance has attempted to minimize unnecessary medical treatment and testing associated with automobile insurance by requiring the treating providers to do nothing more than what they should be doing on a daily basis today. A medical provider

today should be performing a thorough history and examination of the patient. This information should be synthesized into a diagnosis and clinically support a treatment plan that is recorded in the medical record.

A typical treatment plan should include long- and short-term goals, as well as decision point reviews, with these decision point reviews coinciding with patient reexaminations that allow for the analysis of patient's progress or lack thereof. Care path development is performed daily by providers. This process goes by many names such as care plan, discharge planning, treatment protocol, or treatment guideline and should not be considered new to the practice of chiropractic or medicine. Each individual provider has established their own protocols. These protocols spell out the intervals at which decision point reviews and reexaminations are performed and what is medically necessary treatment. The Department of Banking and Insurance has simply taken this process and put it on paper to allow all patients to receive the most appropriate efficacious treatment for their specific condition.

Further, the Department regulations allow for reimbursement of services that fall outside these guidelines when they are clinically supported as medically necessary according to the treatment provider's medical records. It has been suggested that the proposed care paths would lead to a cookie-cutter treatment plan where all patients would receive the same treatment regardless of their individual circumstances. This issue, again, is specifically addressed by the regulation.

The regulation expressly states that treatments outside of the proposed care paths may be considered for reimbursement when clinically supported by the treating provider as medically necessary. It is clearly the

responsibility of the treating provider to document all clinically relevant past and present medical histories that will impact the ongoing treatment of the individual patient. It is the treating provider's duty to provide documentation of a thorough examination and treatment plan that is tailored to the specific patient needs.

This information would simply need to be communicated under proposed regulations to eliminate cookie-cutter treatment plan mentality. I believe that a cookie-cutter mentality exists today in PIP and the proposed care paths will actually eliminate it. It is common in today's environment to see patients examined only one time during a course of treatment that extends several months. It's also common to see referrals for advanced diagnostic testing and specialty consultations without clinically supportive documentation of medical necessity.

I would like to briefly describe a treatment plan I recently reviewed. This treatment plan is all too common in today's environment, and I would further like to demonstrate how the treatment plan of this patient would have been impacted by the proposed regulations.

We had a patient that was in a motor vehicle accident with bills submitted by the provider. A completed history and examination was performed on the initial visit. The treatment record, however, did not support the fact that an examination was performed. It simply had a diagnosis of cervical lumbar sprain/strain. This patient was initiated on a treatment plan consisting of electric stimulation, hot packs, massage, and chiropractic manipulation for a total of 67 visits. These 67 visits took place over an eight-month course of period and were sporadic in nature.

Additionally, during that course of treatment, that eighth-month course of treatment, the chiropractor referred for 13 diagnostic tests, all of which appear on the list and the regulations. All of the above referrals that the doctor made -- the 13 referrals that the doctor had made remained without ongoing reexamination of the patient and without the slightest amount of clinically supportive documentation of necessity. The lack of documentation therefore suggested the referrals for this patient were insignificant to ongoing care and cookie-cutter in nature.

The total cost of this treatment was in excess of \$22,000. I am unfamiliar with any medical or chiropractic research that would conclude 67 treatments, using the exact same treatment modalities over an eight-month period for muscular skeletal ligament injuries is appropriate. If this patient was to be seen by a provider, health protocols proposed by the Department of Banking and Insurance, then the following would occur.

A thorough history and physical examination would be performed;
the treating physician would have to establish a diagnosis and treatment plan;

the physician would have to communicate the results of the examination to the insurer;

the insurer would compare the examination findings and propose treatment plan to the Insurance Department's care paths.

If the proposed treatment plan exceeded or was outside the care paths definition, the file would be referred to a medical director to determine the appropriateness of continued treatment.

With respect to the diagnostic testing performed on this patient, only one test, diagnostic spinal ultrasound, would have been expressly limited by the regulation. All other diagnostic tests and consultations would have been allowed if they were supported as medically necessary by relevant clinical documentation provided by the treating provider. Additionally, the patient could have been allowed additional treatment if they were supporting clinical documentation, unlike the file I previously described where there was no documentation.

In the end, the patient would have been afforded the most appropriate level of service for their individual circumstances. This level of service would have allowed the patient to achieve maximum chiropractic improvement without the costly and unnecessary testing and treatment.

The main difference between treatment rendered in these two scenarios is that the provider would have had to perform a thorough examination and document all information that clinically supports medical necessity. Additionally, the provider would have had to perform reexaminations in accordance with decision point review. The decision point review process would have resulted in development of the most efficacious treatment plan and quickest return to maximum chiropractic improvement.

The regulations do not limit access to chiropractic profession. Unlike many insurance plans today designed to limit chiropractic access, the proposed regulations do not apply additional deductibles or co-pays specifically applicable to chiropractic.

Again I'd like to thank you for the opportunity, for the chance to explain the regulations -- why the regulations will not adversely affect care delivered to the patients.

ASSEMBLYMAN DiGAETANO: Thank you.

Assemblyman Caraballo.

ASSEMBLYMAN CARABALLO: Yes, Commissioner LaVecchia, in her testimony, indicated that the people who were opposed to the protocols, opposed to this regulation, were people who benefited from the status quo right now and were objecting. And I forget her exact language, but she made that point clear. I just want to make sure that I understand something, since you are practitioners who are in favor of the regulations. Are you employees of State Farm or the insurance industry in any way?

DR. GUTTSCHOW: Yes.

MR. OLSEN: Yes.

ASSEMBLYMAN CARABALLO: You are, okay. Now, let me ask you a question. As a practitioner who gets these regulations-- If you-- Everybody else said that they have a problem with the idea that what we have in these care paths are immutable roads to health care. You don't seem to have that problem, so I would like you to address for me, if you would, what I perceive to be the problem as articulated by the other folks who spoke.

The 11:3-4.6, when it comes to medical protocols subsection C, says treatments that vary from the care paths shall be reimbursable only when warranted by reason of medical necessity -- one witness who spoke about the circularity of this process -- shall be reimbursable only when warranted by reason of medical necessity. When we get to the definition of medical

necessity -- and again, I'm asking you to wear your practitioner's hat in this case. When it comes to medical necessity, it defines medically necessary the medical treatment of diagnostic tests which is consistent because of, etc., etc. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the care paths in the appendix as applicable.

As a practitioner, if you were given this language, you would think that there is sufficient flexibility for you to deviate from these care paths and not have to worry about being reimbursed?

DR. GUTTSCHOW: As I understand it, anyway, in the definitions of what the care path is that it is a recommended level of service.

ASSEMBLYMAN CARABALLO: So you are not worried about the fact that the words treatments that vary from the care path shall be reimbursable only. That doesn't worry you?

DR. GUTTSCHOW: Well, only by under cases of medical necessity.

ASSEMBLYMAN CARABALLO: Yes, but medical necessity then winds up as-- I thought that gentleman made a pretty good point.

DR. GUTTSCHOW: Well, protocols--

ASSEMBLYMAN CARABALLO: Protocols.

DR. GUTTSCHOW: --or within the care paths. In other words, they are reimbursable. If you follow the care path to the letter, that should be reimbursable.

ASSEMBLYMAN CARABALLO: But if you decide--

DR. GUTTSCHOW: If it is--

ASSEMBLYMAN CARABALLO: --you don't want to follow the care path. Instead, you've decided for all kinds of other reasons as a doctor that you want to follow a different path, your path, because it has worked for you. Ring, ring, you have to make the call, right? You only get reimbursed if it is medically necessary.

All I'm asking is would that concern you as a medical provider?

DR. OLSEN: It wouldn't concern me as a medical provider, and I'd like to tailor it based on, I believe, the testimony that you are referring to where the provider had suggested that these care paths are so rigid right now that you wouldn't be allowed out of those care paths and then, eventually, become a self-fulfilling circuitous situation where the proposed protocols would eventually become the standard of care even if they aren't now because everybody eventually would be held so strictly to those protocols.

I believe that that won't be necessarily the case. The regulations specifically says that if the treating provider can provide clinically supportive documentation today of medical necessity, then they will not be held strictly to the proposed care paths. So, therefore, if they are not being held to those care paths at this very point in time, the regulations proposed by the Department of Banking and Insurance will not become the standard of care for these patients in the future simply because the providers are being forced when applications are being pigeonholed into the treatment plan that is promulgated.

ASSEMBLYMAN CARABALLO: Okay, and by the way, if that were to happen, then maybe a lot of the problems that were raised today wouldn't be the problems that were raised. It wouldn't be as problematic. All I'm asking and I'm really-- While I've got my own view on some of this stuff,

I'm really trying to objectively listen from the point of view of a health provider. Are you saying that the kinds of concerns that the individuals spoke of today are really not concerns?

DR. OLSEN: I couldn't possibly-- Since I missed most of the morning because I was in the hallway, I couldn't possible address all of the concerns that the providers expressed.

ASSEMBLYMAN CARABALLO: Yes, but most of their concerns were the fact that they felt that as providers -- and, by the way, I happen to subscribe to the possibility that there are some doctors, even some lawyers, that are not just greedy, that they really care about the service they are providing. And what we heard today was doctors who said I'm afraid my hands might be tied. You're saying you don't think their hands would be tied given the language -- the language, not the implementation -- the language in the regulations.

DR. GUTTSCHOW: I think what is being spelled out is there are certain expectations of what the doctors should be doing within their offices as far as examinations and what kind of communication they need to have with the insurance carrier so that everybody is on the same page, and that has never been addressed before.

ASSEMBLYMAN CARABALLO: Thank you.

DR. OLSEN: I believe doctors that are doing the right thing today, doing the appropriate examinations and reexaminations, and providing appropriate medical documentation and treatment to their patients will not be affected by this.

ASSEMBLYMAN CARABALLO: And that would include everybody who spoke today because I'm assuming the inference isn't that people who are worried are worried because they are not doing something right, right?

ASSEMBLYMAN DiGAETANO: Anything else? (no response)

Thank you very much.

Ladies and gentlemen, we appreciate your patience here today. We have a number of witnesses that who were not reached today. As I said earlier, anyone who was not reached today is welcome to submit testimony to this Committee in writing, is also welcomed to come back at a subsequent hearing, and you will notified of that by the Committee.

Thank you very much.

(HEARING CONCLUDED)