Adopted Repeal and New Rule: N.J.A.C. 11:3-4 Appendix, Exhibit 3

Adopted New Rules: N.J.A.C. 11:3-4.10 and 11:3-4 Appendix, Exhibit 11

Adopted Amendments: N.J.A.C. 11:3-3.2, 4.2, 4.4, 4.5, 4.7, 4.8, 4.9, Appendix, Exhibit 10, 5.6 and 14.3

PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

Proposed: December 20, 1999 at 31 N.J.R. 4210(a).

Adopted: October 13, 2000 by Karen L. Suter, Commissioner, Department of Banking and Insurance

Filed: October 16, 2000 as R.2000 d.454, with substantive changes not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 39:6A-3.1a and 39:6A-4.4a.

Effective Date: November 6, 2000.

Expiration Date: January 4, 2001.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance ("Department") received 30 timely written comments regarding this proposal from the following:

1. The Professional Insurance Agents of New Jersey;
2. Alexander M. Padino, DO;
3. David J. Klinger, Esq.;
4. Larry Sabel, DC;
5. Allstate Insurance Company;
6. Anthony Panzica, DC;
7. Michael W. Goione, DC;
8. John M. Dale, DC;
9. New Jersey State Bar Association;
10. State Farm Insurance Companies;
11. Wendi Polhemus, DC;
12. Joseph J. Garolis, DC;
13. William D. Charscham, DC;
14. John J. Pluta, DC;
15. Prudential Property and Casualty Insurance Company of New Jersey;
16. National Association of Independent Insurers;
17. State Board of Dentistry, Division of Consumer Affairs, New Jersey Department of Law and Public Safety;
18. New Jersey Dental Association and Harris M. Colton, DDS by Arthur Meisel, Esq.;
19. Selective Insurance Company;
20. Counsel of New Jersey Chiropractors by the MWW Group;

21. William Campagnolo, DC;

22. Thomas Vangi, DC;

23. State Board of Chiropractic Examiners, Division of Consumer Affairs, Department of Law and Public Safety;

24. Lou Rogers, DC;

25. Alan J. Wolkoff, DC;

26. Alliance of American Insurers;

27. Insurance Counsel of New Jersey;

28. First Trenton Insurance Company;

29. New Jersey Association of Osteopathic Physicians and Surgeons by Alma L. Saravia, Esq.;

30. New Jersey Manufacturers Insurance Group.

Several comments were received shortly after the close of the comment period. The Department has reviewed these comments and determined that they raised substantially the same issues as those raised in comments received timely.

COMMENT: Many comments commended the Department's efforts to clarify the rules implementing the Automobile Insurance Cost Reduction Act ("AICRA") and expressed the opinion that the statute and rules were working to lower the cost of automobile insurance in New Jersey.

RESPONSE: The Department appreciates the support of the commenters.

COMMENT: The Department received numerous comments on proposed N.J.A.C. 11:3-4.4(e) that permits insurers to require insureds, injured persons and health care providers to report information about the injury and the claim and to impose a graduated series of co-payment penalties for failure to supply the required information. Some commenters supported the proposed amendment saying that it was an appropriate means to address the challenge of late reporting of claims and injuries. Other commenters objected to the proposed amendment as follows:

1. Several medical providers stated that the proposed amendment appeared to require medical providers to investigate and report on how the accident occurred (weather, road conditions, speed, mental and emotional condition, culpability and related circumstances) and that doing so would violate the doctor-patient privilege and will constitute an unwarranted intrusion into the relationship of trust that must exist between a patient and doctor. In addition, they argued that health care professionals should spend their time treating those in need of care and not conducting a fraud prevention and detection inquiry.

2. Other commenters stated that when the precertification and decision point review rules were first adopted, providers were promised that their bills would be promptly paid as long as they were clinically supported and medically necessary. Now the Department unfairly seeks to compel providers to act as investigative agents on behalf of insurers to gather evidence which has little or no medical significance. In the event the provider does not meet these arbitrary reporting requirements, substantial economic sanctions will be imposed.

3. Some commenters stated that N.J.A.C. 11:3-25 already requires medical providers to give notice of the commencement of the treatment within 21 days of the first treatment of the patient. The rules do not provide for any reconciliation between the 21 day rule and these new requirements. They asked, for instance, can a 21 day notice also contain the information required to be provided in N.J.A.C. 11:3-4.4(e)

4. Some commenters noted that the time period to send the information to the insurer runs from the date of the accident. The commenters stated that many medical providers do not first see the patient until 60 days after the date of the accident and would automatically be subject to the 50 percent penalty. Other commenters observed that many accident related injuries are not manifested until after the 60 day time period. Thus, post-traumatic stress disorder, TMJ-D, chronic pain and many other problems might not appear until 60 days after the accident. These commenters recommended making the time period for reporting run from the first visit to the provider rather than the date of the accident.

5. One commenter noted that the insured might not have the necessary information to report to the insurer and suggested that the requirement apply to the insured or his or her designee.

RESPONSE: The Department has carefully reviewed the comments received and determined to adopt N.J.A.C. 11:3-4.4(e) with changes. Automobile insurance policies have long included a provision that requires the insured to co-operate with the insurer in providing necessary information to handle the claim. Besides just handling the claims, insurers need this information to fight fraud and make sure that only medically necessary treatment is being reimbursed. The Department's intention in proposing this amendment is to establish rules about sanctions on insureds who failed to fulfill their duty of cooperation in the policy, and permit the development of efficient and integrated claims handling processes to implement AICRA. At the outset, the Department notes that neither the expressed nor intended provisions of the rules were to require providers to investigate auto accidents. To the extent that they routinely collect information related to causation of injuries, however, it is appropriate that it be conveyed as requested to the insurer who pays the claim. In addition, it should be noted that N.J.S.A. 17:33A-9(a) requires providers to report insurance fraud to the Office of the Insurance Fraud Prosecutor.

The comments focused on the fact that providers were included with those subject to the penalty for failure to co-operate. The Department agrees with the commenters that it is unnecessary to include treating medical providers with those subject to this provision because of the other rules governing PIP claims. Treating health care providers are already required to notify insurers 21 days after the commencement of treatment pursuant to N.J.A.C. 11:3-25. In addition, the operation of Decision Point Review/Precertification plans requires that providers notify insurers at various points in the treatment of certain injuries sustained in automobile accidents.

Accordingly, the Department is changing N.J.A.C. 11:3-4.4(e) upon adoption to focus the requirement more clearly on the ability of the insurer to impose penalty co-payments where an insured fails to meet his or her obligation under the policy terms to provide information to the insurers about the claim and injury. It is also not necessary to refer to "injured persons" since anyone who is covered by the policy, whether named or not, is an "insured." It is in the interest of all parties--the insured, the insurer and the provider (who may be the assignee of benefits provided by the policy)--to communicate information necessary to the prompt resolution of the claim.

COMMENT: Several comments were received concerning N.J.A.C. 11:3-4.9(b), which states that certain aspects of an insurer's decision point plan can be exempt from public inspection and copying permitted by the "Right-to-Know" law, N.J.S.A. 47:1A-1 et seq. Several comments supported the Department's recognition of insurer's proprietary information. Other commenters objected to the amendment stating that since insurers will be permitted to identify parts of their precertification plans as containing "proprietary information," there should be a definition of that term to prevent overreaching by insurers.

RESPONSE: The Department appreciates the support. Concerning the suggestion that the proposed amendment include a limiting definition of "proprietary," the Department disagrees with the commenters. First, "proprietary" does not need a special definition in the rule because the Department intends that it retain its common usage definition. Secondly, the Department notes that as part of its Decision Point Review plan filing, an insurer may include copies of contracts with vendors, lists of employees or vendors, internal workflows and other materials that it considers to be proprietary, trade secret information. These documents assist the Department in evaluating an insurer's filing. As these documents vary by insurer, it is not feasible to list them, or to otherwise limit what may be "proprietary." Regarding publicly available information about the approved plans, it should be noted that all of the documents in an insurer's Decision Point Review Plan that are intended to explain to policyholders, injured persons or providers the working of the plan are public and are not proprietary. The Department's intention in proposing the amendment was not to prevent interested parties from obtaining copies of the decision point review plan materials that the insurer provides to policyholders and providers.

COMMENT: Several comments on the reporting requirements established in N.J.A.C. 11:3-4.10 and in the reporting form, Appendix Exhibit 11, stated that insurers should also be required to report the medical discipline of those providers whose treatment, testing, and precertification requests are denied. The commenters argue that this will permit the Department to discern if insurers are discriminating against one kind of medical care. Other commenters stated that producing the reports monthly was burdensome and requested that the reports be submitted quarterly.

RESPONSE: The Department does not agree with the suggestions of the commenters. The form is designed to elicit information on the claims practices of insurers as reflected in the number of claims appealed in relation to the total number of claims filed. There is no information regarding the specific grounds for denial and, thus, the Department considers that no useful conclusions could be reached by identifying the medical discipline of a provider whose claims are denied. Concerning the frequency of reporting, the Department, in consultation with the Personal Injury Protection Technical Advisory Commission ("PIPTAC"), reviews the usefulness of the reports created from the information pro-

vided by insurers in monitoring implementation of the PIP reforms and may propose amendments to the reporting requirements in the future. At this time, however, the Department requires this information to be reported promptly so as to alert it to any implementation issue that may require further examination.

COMMENT: Many comments were received on the language Appendix, Exhibit 10. A number of the comments referred to parts of the Exhibit that were not proposed for amendment. Other commenters stated that the language in the proposed amendment that "a limited course of spinal manipulation may be considered, however, as conservative therapy on Care Paths 2, 4, and 6. If no improvement within one month, discontinue" was inconsistent with the previous sentence that: "There is insufficient evidence to recommend manipulation for patients with radiculopathy." They stated that the value of spinal manipulation/chiropractic care is clearly documented and recognized in the treatment of traumatic injuries including those with radicular symptoms. Other commenters objected to the word "discontinue" and suggested "re-evaluate."

RESPONSE: The amendment to Exhibit 10, number 3 was made to clarify the Department's intent in amendments made upon adoption of the original rule that manipulation can be considered as part of conservative treatment in all the Care Paths provided that test results do not indicate that manipulation would be harmful. As the commenters noted, however, the addition of the sentence at the end of the paragraph does not adequately express this intent. Other comments request a substantive change, rather than the clarification intended. Therefore, the Department is amending this Exhibit upon adoption to substitute "re-evaluate" for "discontinue" and to incorporate language suggested by the Board of Chiropractic Examiners that better expresses the Department's intent. The Department would like to acknowledge the excellent suggestions for revisions to the Exhibit made by the Board of Chiropractic Examiners.

COMMENT: Many commenters expressed their support for the definition of "significant disfigurement" as used in N.J.A.C. 11:3-4.2. As noted, this definition is used to establish the criteria that will cause the $ 15,000 PIP expense benefits limit in basic policies and reduced PIP maximum coverage in standard policies to be increased up to $ 250,000. One commenter suggested that the conjunction ought to be "or" in the part of the definition that requires significant disfigurement to effect "the appearance and functional ability of the person injured."

Some of the commenters urged the Department to apply this definition to the same term used in the "limitation on lawsuit" threshold for suits for non-economic losses (see N.J.S.A. 39:6A-8a), while others wanted it specifically noted that the definition did not apply to the definition of the threshold.

RESPONSE: The Department acknowledges the support expressed for the definition of "significant disfigurement." The definition was proposed in response to comments on the original adoption of N.J.A.C. 11:3-3.2 and 14.3 and any other application of the definition is beyond the scope of this proposal. The Department does not agree with the suggestion that the definition should read, "the appearance or functional ability of the person injured." The Department consulted with the PIPTAC in the development of this definition and believes that a significant disfigurement should involve impairments in both function and appearance.

COMMENT: Many comments were received in support of the amendments to N.J.A.C. 11:3-4.5 that establish separate rules for the diagnostic testing for temporomandibular joint disorder ("TMJ/D") and other dental injuries.

RESPONSE: The Department once again acknowledges the assistance of the Board of Dental Examiners for its contributions to these amendments.

COMMENT: Several comments were received on the lists of diagnostic tests in N.J.A.C. 11:3-4.5. One commenter stated that the definition of "diagnostic test" should also include those tests which are used to confirm or rule out a diagnosis.

Several comments were received on the inclusion of brain mapping as reimbursable "when done in conjunction with appropriate neurodiagnostic testing." One commenter stated that this would result in the over-utilization of this test and suggested the addition of a threshold test for the procedure. Another commenter suggested that an evidence-based guideline for this test be developed if it used in a significant number of cases. Another commenter suggested that brain mapping should be more specifically defined a "Quantitative or Sleep Deprivation EEG" and that it should be included with the tests requiring decision point review under N.J.A.C. 11:3-4.5(b). Another commenter agreed that brain mapping should be reimbursable but proposed language from the Academy of Medicine Neurology Section, which states that brain mapping "must be performed with a high standard of quality in conjunction with analysis of concurrent polygraph EEG."

Concerning the use of needle electromyography, a commenter suggested excluding its administration in situations, "where clinically supported findings reveal numbness and tingling." These symptoms, according to the commenter, are subjective and do not ordinarily call for the administration of the test.

A commenter stated that it is not clear that thermograms are diagnostic of reflex sympathetic dystrophy (RSD) and noted that they are not recommended in other nationally-accepted guidelines. Another commenter stated that the use of thermograms as a component in a diagnostic work-up for RSD is widely accepted in the medical community and supported the proposed change.

A comment was received on the proposed elimination of "medical" from the term "trained medical professional" in N.J.A.C. 11:3-4.5(c). The commenter suggested that "health care provider" would be more appropriate to track the statute and reflect the need for licensing and certification.

RESPONSE: The Department notes that the definition of "diagnostic test" and the guidelines for administration of the tests come from rules proposed and adopted by the State Board of Dentistry, the State Board of Medical Examiners, and the State Board of Chiropractic Examiners (collectively the "Professional Boards") and would refer the commenters to those entities to suggest changes to those rules.

Concerning the location of brain mapping in N.J.A.C. 11:3-4.5(a), the Department agrees that since it is permitted under limited circumstances, it should be included in N.J.A.C. 11:3-4.5(b) and has so amended the rule upon adoption. The Department also agrees with the commenter that the term defined in the rule, "health care provider," is a more appropriate way to address the concerns raised about use of "trained medical professional" and has so amended the rule upon adoption.

COMMENT: Several commenters questioned whether the Department intended to repeal N.J.A.C. 11:3-5.6(d)3 that provided for the allowance of attorneys fees to a successful claimant or respondent in alternative dispute resolution proceedings. Several commenters stated that only the words "or respondent" needed to be deleted by the Appellate Division decision in New Jersey Coalition of Health Care Professionals, Inc., et al v. New Jersey Department of Banking and Insurance, 323 N.J. Super. 207 (App. Div. 1999), certif. denied, 162 N.J. 485 (1999).

RESPONSE: The Department did not intend to totally limit the ability of the dispute resolution professional to award attorney's fees. It agrees with the commenter that only the deletion of "or respondent" is required by the Appellate Division decision and has made the change retaining N.J.A.C. 11:3-5.6(d)13, but deleting "or respondent" upon adoption.

COMMENT: Concerning the proposed amendments to N.J.A.C. 11:3-4.8, one commenter did not believe that the language of the rule is consistent with the statute. The commenter noted that N.J.S.A. 39:6A-4 permits insurers to mandate, "precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods as approved by the Commissioner." The proposed amendment excludes from precertification those injuries and tests that are subject to decision point review and the commenter concludes that the rule would permit all other injuries to be subject to precertification.

The commenter also notes that the proposed amendment only limited precertification to those treatments subject to overutilization. This, the commenter believes, is too vague, permits the insurers to require precertification of all treatments and labels physicians who wish to order treatments that must be precertified as "overutilizers." The commenter believes that a reasonable definition of "overutilized" should be developed so that physicians can know which tests or treatments are on the overutilized list.

RESPONSE: The commenter misinterprets the Department's intent in amending these rules. The rules as originally adopted permitted insurers to file for approval a precertification plan that could satisfy the requirement to have a decision point review plan. The proposed amendments eliminated the ability of insurers to file a comprehensive precertification plan and instead require that all insurers file a decision point review plan that states how the insurer will request and process decision point review requests at the decision points on the Care Paths and for the list of diagnostic tests in N.J.A.C. 11:3-4.5(b). The decision point review plan can include a separately identified list of treatments, diagnoses or tests for which precertification is required. As noted by the commenter, the diagnoses and tests subject to the Decision Point Review requirements, including the Care Paths, cannot be subject to precertification because the decision point review notice system already provides insurers a way to monitor treatment of those injuries.

The proposed amendment does not define what treatments, diagnoses and tests are subject to overutilization. The Department believes that insurers are in the best position to decide those treatments, diagnoses or tests for which the

benefits of precertification in reducing unnecessary treatment outweigh the cost of administering a utilization review program. The treatments or tests that are overutilized may change over time and the rules recognize that flexibility is necessary. However, as part of a decision point review plan, precertification requirements are subject to review and approval by the Department. The Department will not approve any precertification requirements that have the effect of requiring precertification for "all" treatments or diagnoses. With regard to the commenter's statement that providers will be "labeled as overutilizers" if they order treatments or tests that require precertification, the Department does not agree. The precertification requirements of approved plans are very similar to those subject to utilization review under the Individual and Small Employer Health Plans pursuant to N.J.A.C. 11:20 and 11:21.

Federal Standards Statement

A Federal standards analysis is not required because the adopted amendments and new rules relate to the business of insurance and are not subject to any current Federal requirements or standards.

Full text of the adoption follows (additions to proposal indicated in boldface with underlining and asterisks ***thus***: deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 3. BASIC AUTOMOBILE INSURANCE POLICY

11:3-3.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meaning unless the context clearly indicates otherwise.

"Significant disfigurement" means the result and/or manifestation of a serious traumatic injury that is observable as a permanent and substantial defect in the appearance and functional ability of the person injured. "Significant disfigurement" is a serious outward change that substantially detracts from the appearance and functional ability of the person injured.

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

11:3-4.2 Definitions

The following words, phrases and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Diagnostic test" means a medical service or procedure utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical, dental, physical therapy, chiropractic or psychological diagnosis, for the purpose of recommending or developing a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

11:3-4.4 Deductibles and co-pays

(a)-(d) (No change.)

(e) An insurer may require that the insured*[, injured person and/or treating health care provider]* advise and inform the insurer about the injury and the claim. This requirement may include the production of information from the insured*[, injured person or provider]* regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment.

1. This information may be required to be provided as promptly as possible after the accident, and periodically thereafter.

2. An insurer may impose an additional co-payment as a penalty for failure to supply the required information. Such penalties shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. The additional co-payment shall be an amount no greater than:

i. Twenty-five percent when received 30 or more days after the accident; or

ii. Fifty percent when received 60 or more days after the accident.

3. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

4. Information about this requirement and how to comply with it shall be included in the informational materials required by N.J.A.C. 11:3-4.7(d).

(f) (No change in text.)

11:3-4.5 Diagnostic tests

(a) The personal injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, which have been determined to yield no data of any significant value in the development, evaluation and implementation of an appropriate plan of treatment for injuries sustained in motor vehicle accidents:

1.-5. (No change.)

[6. Brain mapping, when not done in conjunction with appropriate neurodiagnostic testing.]

Recodify existing 7.-9. as ***6.-8.*** (No change in text.)

(b) The personal injury protection medical expense benefits coverage shall provide for reimbursement of the following diagnostic tests, which have been determined to have value in the evaluation of injuries, the diagnosis and development of a treatment plan for persons injured in a covered accident, when medically necessary and consistent with clinically supported findings:

1. Needle electromyography (needle EMG) when used in the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling. A needle EMG is not indicated in the evaluation of TMJ/D and is contraindicated in the presence of infection on the skin or cellulitis. This test should not normally be performed within 14 days of the traumatic event and should not be repeated where initial results are negative. Only one follow up exam is appropriate.

2.-4. (No change.)

5. Magnetic resonance imaging (MRI) when used in accordance with the guidelines contained in the American College of Radiology, Appropriateness Criteria to evaluate injuries in numerous parts of the body, particularly the assessment of nerve root compression and/or motor loss. MRI is not normally performed within five days of the insured event. However, clinically supported indication of neurological gross motor deficits, incontinence or acute nerve root compression with neurologic symptoms may justify MRI testing during the acute phase immediately post injury. In the case of TMJ/D where there are clinical signs of internal derangement such as nonself-induced clicking, deviation, limited opening, and pain with a history of trauma to the lower jaw, an MRI is allowable to show displacement of the condylar disc, such procedure following a panographic or transcranial x-ray and six or eight weeks of conservative treatment. This TMJ/D diagnostic test may be repeated post surgery and/or post appliance therapy.

6. Computer assisted tomographic studies (CT, CAT Scan) when used to evaluate injuries in numerous aspects of the body. With the exception of suspected brain injuries, CAT Scan is not normally administered immediately post injury, but may become appropriate within five days of the insured event. Repeat CAT Scans should not be undertaken unless there is clinically supported indication of an adverse change in the patient's condition. In the case of TMJ/D where there are clinical signs of degenerative joint disease as a result of traumatic injury of the temporomandibular joint, tomograms may not be performed sooner than 12 months following traumatic injury.

7. (No change.)

8. Sonograms/ultrasound when used in the acute phase to evaluate the abdomen and pelvis for intra-abdominal bleeding. These tests are not normally used to assess joints (knee and elbow) because other tests are more appropriate. Where MRI is performed, sonograms/ultrasound are not necessary. However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

9. Thermography/thermograms only when used to evaluate pain associated with reflex sympathetic dystrophy ("RSD"), in a controlled setting by a physician experienced in such use and properly trained.

10. Brain mapping, when done in conjunction with appropriate neurodiagnostic testing.

(c) The terms "normal," "normally," "appropriate" and "indicated" as used *[above]* in (b) **<u>*above*</u>**, are intended to recognize that no single rule can replace the good faith educated judgment of a *[trained professional]* **<u>*health care provider*</u>**. Thus, "normal," "normally," "appropriate" and "indicated" pertain to the usual, routine, customary or common experience and conclusion, which may in unusual circumstances differ from the actual judgment of course of treatment. The unusual circumstances shall be based on clinically supported findings of a *[trained professional]* **<u>*health care provider*</u>**. The use of these terms is intended to indicate some flexibility and avoid rigidity in the application of these rules in the decision point review required in (d) below.

(d)-(e) (No change.)

(f) Pursuant to N.J.A.C. 13:30-8.22(b), the personal injury protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

1. Mandibular tracking;

2. Surface EMG;

3. Sonography;

4. Doppler ultrasound;

5. Needle EMG;

6. Electroencephalogram (EEG);

7. Thermograms/thermographs;

8. Video fluoroscopy; and

9. Reflexology.

11:3-4.7 Decision point review

(a)-(b) (No change.)

Recodify existing (d)-(e) as (c)-(d) (No change in text.)

11:3-4.8 Precertification

(a) Insurers may require precertification of certain specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.

(b) Precertification requirements shall be included with a decision point review plan submission but the medical procedures, treatments, diagnostic tests, durable medical equipment or other services that require precertification shall be identified separately from decision point review.

Recodify existing (b)-(c) as (c)-(d) (No change in text.)

(e) An insurer that wishes to use precertification shall designate a licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that:

1.-3. (No change.)

(f) The insurer shall include precertification requirements in the information about its decision point review plan that will be given to consumers with new and renewal policies and upon notice of a claim. The consumer information shall include at a minimum the items in N.J.A.C. 11:3-4.7(d).

(g) (No change in text.)

(h) Policy forms may include an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with precertification requirements.

(i) Precertification shall avoid undue interruptions in a course of treatment.

(j) Insurers are encouraged to permit a treating provider to submit a comprehensive treatment plan for precertification so as to minimize the need for piecemeal review.

11:3-4.9 Assignment of benefits; public information

(a) Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.

(b) An insurer shall identify documents containing proprietary information in its decision point review plan submission. Documents containing proprietary information shall be confidential and shall not be subject to public inspection and copying pursuant to the "Right-to-Know" law, N.J.S.A. 47:1A-1 et seq. The Department shall notify the insurer prior to responding to any public record request for proprietary information.

11:3-4.10 Reporting requirements

(a) Insurers shall file with the Department a completed monthly decision point review/precertification implementation report (Appendix Exhibit 11, incorporated herein by reference) on the 10th day of each month which reflects the reported activity as of the last day of the premium month.

(b) The report referred to in (a) above shall be filed on paper and on diskette or by e-mail using an Excel spreadsheet format with data contained in one computer file. This filing shall be e-mailed to cday@dobi.state.nj.us or mailed to:

New Jersey Department of Banking and Insurance
Office of Property and Casualty Insurance
Attn: Statistical Unit
PO Box 325
Trenton, NJ 08625-0325

[See original in print version]

EXHIBIT 10

ADDENDUM TO CARE PATHS

1.-2. (No change.)

3. Spinal Manipulation***/Chiropractic Care***

[Manipulation is most helpful for patients with acute neck, thoracic, and low back problems without radiculopathy when used within the first month of symptoms. A trial of manipulation in patients without radiculopathy with symptoms longer than a month is probably safe, but efficacy is unproven. If manipulation has not resulted in symptomatic improvement that allows increased function after 1 month of treatment, the patient should be re-evaluated.] ***A course of spinal manipulation/chiropractic care may be considered as conservative therapy on all Care Paths. If there is no improvement within one month, then immediate reevaluation is indicated to determine appropriate further treatment and treatment options, including referral to other health care providers and/or modification of conservative therapy.***

When findings suggest progressive or severe neurologic deficits, an appropriate diagnostic assessment to rule out serious neurologic conditions is indicated *[before beginning manipulation therapy]* ***in any conservative therapy***.

[There is insufficient evidence to recommend manipulation for patients with radiculopathy. A limited course of spinal manipulation may be considered, however, as conservative therapy on Care Paths 2, 4 and 6. If no improvement within one month, discontinue.]

4. (No change.)

SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

11:3-5.6 Conduct of PIP dispute resolution proceedings

(a)-(c) (No change.)

(d) Determination by the dispute resolution professional shall be in writing and shall state the issues in dispute, the DRP's findings and legal conclusions based on the record of the proceedings and the determination of the medical review organization, if any. The findings and conclusions shall be made in accordance with applicable principles of substantive law, the provisions of the policy and the Department's rules. The award shall set forth a decision on all issues submitted by the parties for resolution.

1.-2. (No change.)

3. The award may include attorney's fees for a successful claimant in an amount consonant with the award and with Rule 1.5 of the Supreme Court's Rules of Professional Conduct.

(e)-(f) (No change.)

SUBCHAPTER 14. PERSONAL INJURY PROTECTION OPTIONS FOR STANDARD POLICIES

11:3-14.3 Optional medical expense benefits for standard policies

(a)-(b) (No change.)

(c) "Significant disfigurement" as used in (b) above means the result and/or manifestation of a serious traumatic injury that is observable as a permanent and substantial defect in the appearance and functional ability of the person injured. "Significant disfigurement" is a serious outward change that substantially detracts from the appearance and functional ability of the person injured.