

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

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

Proposed 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

Proposal Number: PRN 1999-477.

PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOL; DIAGNOSTIC TESTS

Authorized By: Jaynee LaVecchia, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 39:6A-3.1 and 39:6A-4.

Submit comments by January 19, 2000 to:

Jean M. Bickal, Acting Assistant Commissioner
Legislative and Regulatory Affairs
Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625-0325

The agency proposal follows:

Summary

On November 30, 1998, the Department of Banking and Insurance ("Department") adopted N.J.A.C. 11:3-4 (at 30 N.J.R. 4401(a)); N.J.A.C. 11:3-3 (at 30 N.J.R. 4398(a)) and amendments to N.J.A.C. 11:3-14 (at 30 N.J.R. 4390(b)) to implement some of the mandates of the Automobile Cost Reduction Act, P.L. 1998, c.21 and c.22 ("AICRA" or "the Act"). The Department is proposing amendments to these rules as follows:

In response to comments made when N.J.A.C. 11:3-4 was originally proposed, the Department also proposing to amend N.J.A.C. 11:3-3.2 and 14.3 to add a definition for the term "significant disfigurement" as used in N.J.S.A. 39:6A-3.1a and 6A-4.3e. This term is used as part of the definition of injuries that trigger PIP medical expense benefits to be increased up to \$ 250,000 from \$ 15,000 for Basic policies (see N.J.A.C. 11:3-3), or from the lower PIP limits set forth in N.J.A.C. 11:3-14.2. The Department consulted with the Personal Injury Protection Technical Advisory Committee ("PIPTAC") created by Department Order A99-113 in establishing the definition.

A new N.J.A.C. 11:3-4.4(e) is proposed in order to encourage the development of integrated systems for the receipt and utilization of information related to PIP medical expense benefit claims, and to promote the Act's goals of reducing PIP fraud and abuse. Pre AICRA auto insurance policies referenced the duty of claimants to provide necessary information about all PIP claims, and current policies that reflect AICRA changes provide structure for the receipt of necessary medical benefit claim information and establish sanctions for failure to provide it. The proposed rule recognizes these existing duties and provides an enforceable mechanism for obtaining the information. Proposed N.J.A.C. 11:3-4.4(e) provides that an insurer furnish notice and instructions to claimants and health care providers about any special requirements that may result in penalty co-payments, which is to be included in the information distributed with the insurer's decision point review plan.

At the time the Department adopted N.J.A.C. 11:3-4, the Board of Dentistry, the State Board of Medical Examiners, the Board of Physical Therapy and the Board of Chiropractic Examiners (collectively the "Professional Boards") had proposed but not yet adopted rules pertaining to the validity of diagnostic testing for injuries sustained in automobile accidents as directed by the Act. In proposing and adopting N.J.A.C. 11:3-4, the Department had consulted with an ad hoc committee of the Professional Boards. Comments from certain Professional Boards were reflected in the rules as adopted. Since that time, however, the Professional Boards have adopted rules concerning diagnostic tests as required by the Act. (See 31 N.J.R. 651(a) to 668(a)). In most instances, these adopted rules were consistent with N.J.A.C. 11:3-4.

Pursuant to N.J.S.A. 39:6A-4.7, the Department must approve the list of valid diagnostic tests developed by the Professional Boards. The Department is proposing amendments to N.J.A.C. 11:3-4 to incorporate changes made in the Professional Boards' rules as adopted. In some cases, the rules adopted by the Professional Boards are not entirely consistent with each other or do not address standards for the treatment of auto accident related trauma. Where conflicts exist, the Department has chosen to follow the rules of the Board of Medical Examiners.

It should also be noted that the Board of Dentistry adopted rules that only apply to diagnostic testing for traumatically induced temporomandibular joint disorder (TMJ/D) and do not apply to any other trauma related injuries. In order to reconcile N.J.A.C. 11:3-4.5 with the rules adopted by the Board of Dentistry, the Department has set forth the diagnostic testing rules not reimbursable for TMJ/D in N.J.A.C. 11:3-4.5(f), separately from those that apply to all other traumatically induced injuries. The Department has also amended N.J.A.C. 11:3-4.5(b)5 and 6 to include the standards adopted by the Board of Dentistry for using MRI and tomography in diagnosing TMJ/D.

N.J.A.C. 11:3-4.2 is proposed to be amended to add a definition for "diagnostic tests" that is consistent with the term as used by the Professional Boards. N.J.A.C. 11:3-4.5(a)6 is proposed for amendment to achieve compliance with the rules adopted by the State Board of Medical Examiners which permit brain mapping when done in conjunction with appropriate neurodiagnostic testing. (See N.J.A.C. 13:35-2.6(c)1v.) N.J.A.C. 11:3-4.5(b)1 is proposed to be amended to remove the word "staph" from the needle EMGs diagnostic test rule. This will provide consistency with the State Board of Medical Examiners' adopted rules. (See N.J.A.C. 13:35-2.6(c)2ii.)

N.J.A.C. 11:3-4.5(b) is proposed for amendment to add a new paragraph 9, to establish rules for the use of thermograms and thermography to evaluate pain associated with reflex sympathetic dystrophy (RSD) when performed by a trained physician under controlled circumstances. This action is consistent with the rules adopted by the State Board of Medical Examiners (see N.J.A.C. 13:35-2.6(c)2i) and the Board of Chiropractic Examiners (see N.J.A.C. 13:44E-3.2(c)3).

N.J.A.C. 11:3-4.5(c) is proposed for amendment to delete the word "medical" from description of the words "normal," "normally," "appropriate" and "indicated" when used in N.J.A.C. 11:3-4. As noted by the adoptions of the Board of Dentistry, the Board of Physical Therapy, the Board of Chiropractic Examiners and in a comment to the Department made by the Board of Psychological Examiners, the use of the word "medical" unnecessarily restricts the meaning of the provision. The Department's intent is more properly served by removing the word "medical" to reflect all properly trained and licensed professional, medical or otherwise.

Since the adoption of N.J.A.C. 11:3-4, the Department has received decision point review and precertification plans from many insurers. In the process of reviewing the plans, meeting with insurers and discussion with the PIPTAC, the Department has refined its requirements concerning precertification. Some of the Department's concerns were previously expressed in Bulletins 99-05 and 99-07 and the Department is proposing to amend N.J.A.C. 11:3-4.7 and 4.8 to codify these refinements.

N.J.A.C. 11:3-4.7(c) is proposed to be deleted. As indicated by the proposed amendments to N.J.A.C. 11:3-4.8, the Department has determined that precertification requirements should be a separate section of a decision point review plan. The proposed amendments to N.J.A.C. 11:3-4.8 permit insurers to precertify certain specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and may be subject to overutilization. These precertification requirements are to be included with a decision point review plan but must be identified separately from decision point review. The proposed amendment further requires that the insurer include any precertification requirements with the consumer information about decision point review.

The Department is closely monitoring the implementation of the changes to PIP mandated by AICRA. In consultation with the PIPTAC, the Department developed a reporting format to track the number and outcome of decision point review and precertification requests handled by insurers. On September 9, 1999, the Department issued Order No. A99-153, which directs insurers to file monthly reports on the number of decision point and precertification requests made. The report also contains data regarding the number of denials, revised approvals, physical examinations scheduled and conducted and other data. The Department is proposing a new rule, N.J.A.C. 11:3-4.10, to codify this reporting requirement and is proposing a new Appendix Exhibit 11 to add to the reporting form.

The Department recognizes that decision point review plans and other submissions to the Department may contain proprietary information. The Department proposes to amend N.J.A.C. 11:3-4.9 to permit insurers to identify any documents containing proprietary information. The Department will not release documents that contain proprietary information and will notify the insurer prior to responding to any public record request for documents designated as proprietary.

As part of the challenge to the validity of N.J.A.C. 11:3-4 (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, (November 10, 1999), the Department was informed of an apparent inconsistency between Care Path 1 (Exhibit 3) and Care Paths 3 and 5 (Exhibits 5 and 7). The alternatives for treatment "four weeks post injury" in Care Path 1 is not entirely consistent with the language used in Care Paths 3 and 5. The Department has always intended for Care Paths 1, 3 and 5 to be essentially the same since no discernible reason exists for them to differ. The Department believes that it is appropriate to amend Exhibit 3 to be consistent with Exhibit 5 and 7. The Department is repealing the existing Exhibit 3 and proposes to adopt a new Exhibit 3 to reflect this correction.

The Department is also proposing to repeal N.J.A.C. 11:3-5.6(d)3 as it was determined to be invalid by the Appellate Division in the decision referenced above.

In response to comments on the original proposal of N.J.A.C. 11:3-4, the Department agreed that Care Paths 2, 4 and 6 should be amended upon adoption to permit a limited course of spinal manipulation if testing for the source of the radiculopathy was negative and the provider believed that treatment would benefit the patient. Although an amendment upon adoption was made to the Care Paths, the Department has received comments from members of the chiropractic profession that the Care Paths 2, 4 and 6 could be interpreted to permit such manipulation for only the most serious injuries--Herniated disc with Radiculopathy and Severe Neurological Compression on Compromise. This was not the Department's intent. The Department is therefore proposing an amendment to Appendix 10 to add to the information about spinal manipulation. The amendment provides that a limited course of spinal manipulation may be considered as part of Conservative Therapy on Care Paths 2, 4 and 6, consistent with the Department's amendment to the Care Paths upon the earlier adoption.

Social Impact

These proposed new rules and amendments will have a beneficial social impact by clarifying the requirements of AICRA as it relates to PIP medical expense benefits. The proposed new rules and amendments make it easier for insurers, insureds and providers to understand and comply with the requirements.

Economic Impact

Many of these proposed new rules and amendments clarify existing requirements and will have a minimal economic effect on private passenger automobile insurers, insureds and the Department. Insurers will be required to bear the cost of submitting the monthly reports on decision point review and precertification requests received. Insurers were notified of the general information the Department would be collecting for this purpose by Bulletin 99-05 in March, 1999. The Department believes that a close monitoring of the implementation of the PIP reforms will benefit all parties.

The Department is also proposing a new rule that permits insurers to impose co-payment penalties for the failure to provide necessary information to the insurer about a loss. If imposed, the co-payments could have a negative financial impact on insureds and a derivative impact on providers. The obligation to cooperate with the insurer upon the occurrence of a loss is a longstanding policy provision and is important to combat fraud. Insurers provide their insureds with information on how to contact them in case of a loss. The co-payments will not begin until failure to notify has extended more than 30 days. The Department believes that the penalty co-payments are a reasonable way for insurers to get vital information needed to prevent fraud and that insureds acting in good faith will not suffer any adverse economic effect from the proposed new rule.

Federal Standards Statement

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

Jobs Impact

The Department does not believe that the proposed new rules and amendments will have any impact on jobs. However, the Department invites interested persons to submit any data or studies about the jobs impact of these proposed rules with their written comments.

Agriculture Industry Impact

The Department does not anticipate any impact from the proposed amendments and new rules upon agriculture and related industries.

Regulatory Flexibility Analysis

These proposed amendments and new rules impose compliance requirements upon private passenger automobile insurers, some of which may be small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Pursuant to N.J.A.C. 1:30-3.1(f)4, the Department provides the following regulatory flexibility analysis regarding those small businesses upon which the proposed new rules impose compliance requirements. A few auto insurers transacting business in New Jersey are small businesses. These auto insurers will be required to file monthly reports on their implementation of decision point review and precertification. These costs may include the cost of computer programming and systems consultants if such services are not available to the insurer in-house. These costs cannot be accurately estimated by the Department at this time since they vary greatly based upon insurer.

These rules provide no different compliance standard for small business insurers. All auto insurance policies are required to provide the PIP medical expense benefits as set forth in N.J.S.A. 39:6A-4 and section 4 of the Act. These rules provide standards intended to ensure that PIP medical benefits are provided as required by the Act. In order to assure that all PIP coverage provided by auto insurers meets the minimum requirements of the Act and these rules, no differing compliance requirements for automobile insurers based on business size is appropriate.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:3-4 Appendix, Exhibit 3.

Full text of the proposed amendments and new rules follows (additions indicated underlined and in boldface **thus**; deletions indicated in brackets [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.

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

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:

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

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

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

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).

[(e)] **(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.**

7.-9. (No change.)

(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 [staph] 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 panoramic 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. [CAT Scan is not appropriate for TMJ/D.] 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. [These tests should not be used to evaluate TMJ/D.] However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

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.

(c) The terms "normal," "normally," "appropriate" and "indicated" as used above in (b), are intended to recognize that no single rule can replace the good faith educated judgment of a trained [medical] professional. 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 [medical] professional. 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.)

[(c) Notwithstanding the requirements of (b) above, a pre-certification plan filed and approved pursuant to N.J.A.C. 11:3-4.8 shall satisfy the requirement to have a decision point review plan.]

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

11:3-4.8 Precertification [plans]

(a) Insurers may [file for approval policy forms that provide for a] **require** precertification of certain **specific** medical procedures, treatments, diagnostic tests, [or] other services[, non-medical expenses] and durable medical

equipment [by the insurer or its designated representative] **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 pre-certification shall be identified separately from decision point review.

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

[(d)],**(e)** An insurer that wishes to use [a] precertification [plan] 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.)

[(e)] **(f)** The insurer shall include [with its filing, the] **precertification requirements in the** information about its [pre-certification] **decision point review** plan that will be given to consumers with new and renewal policies [after the pre-certification plan is approved] 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).

[(f)] **(g)**(No change in text.)

[(g)] **(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 [an approved] precertification [plan] **requirements.**

[(h)] **(i)** Precertification [plans] shall avoid undue interruptions in a course of treatment.

[(i)] **(j)** Insurers are encouraged to [provide pre-certification plans that] 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 [including] **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

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 or respondent 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

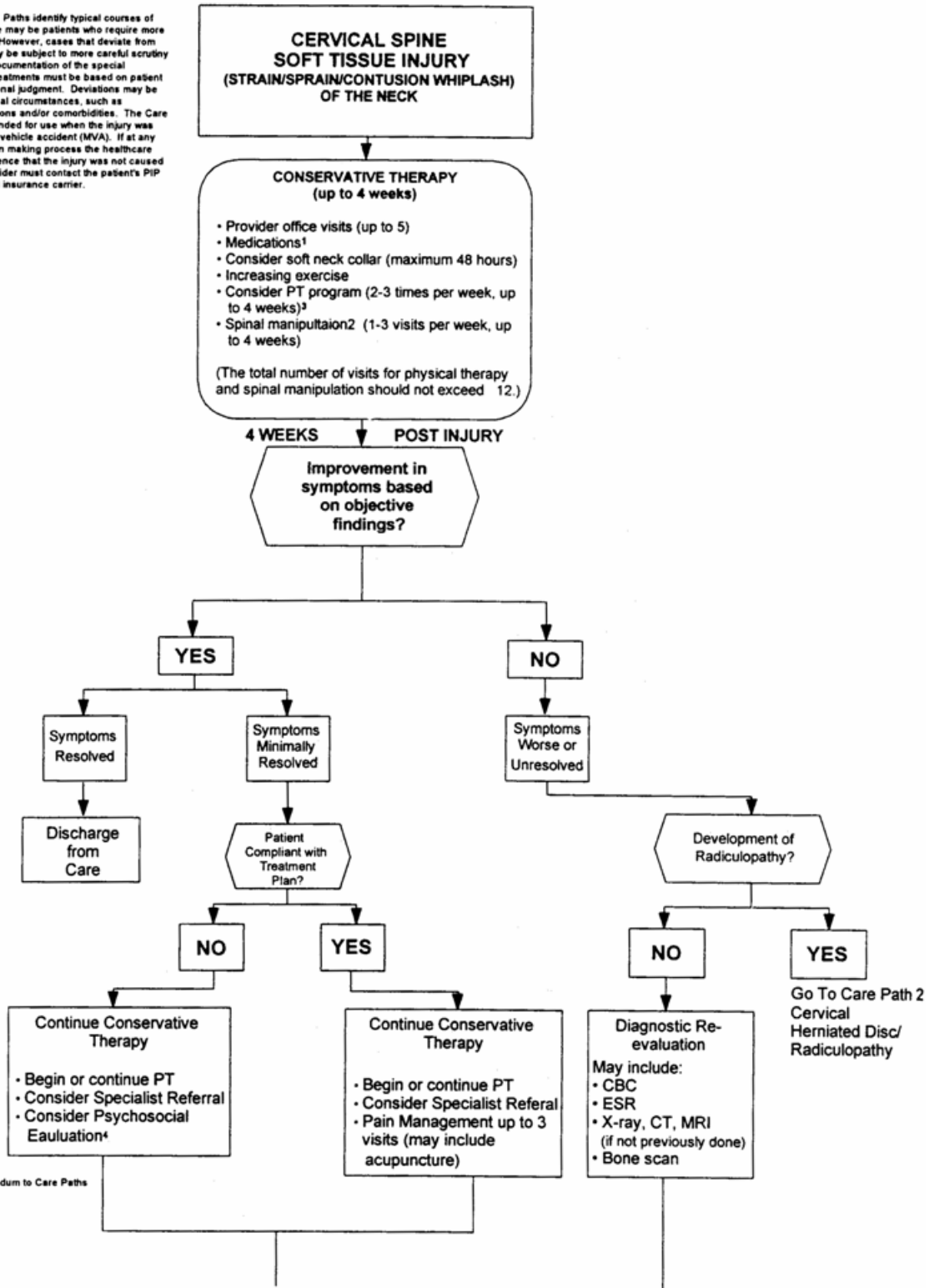
(a)-(b) (No change.)

(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.

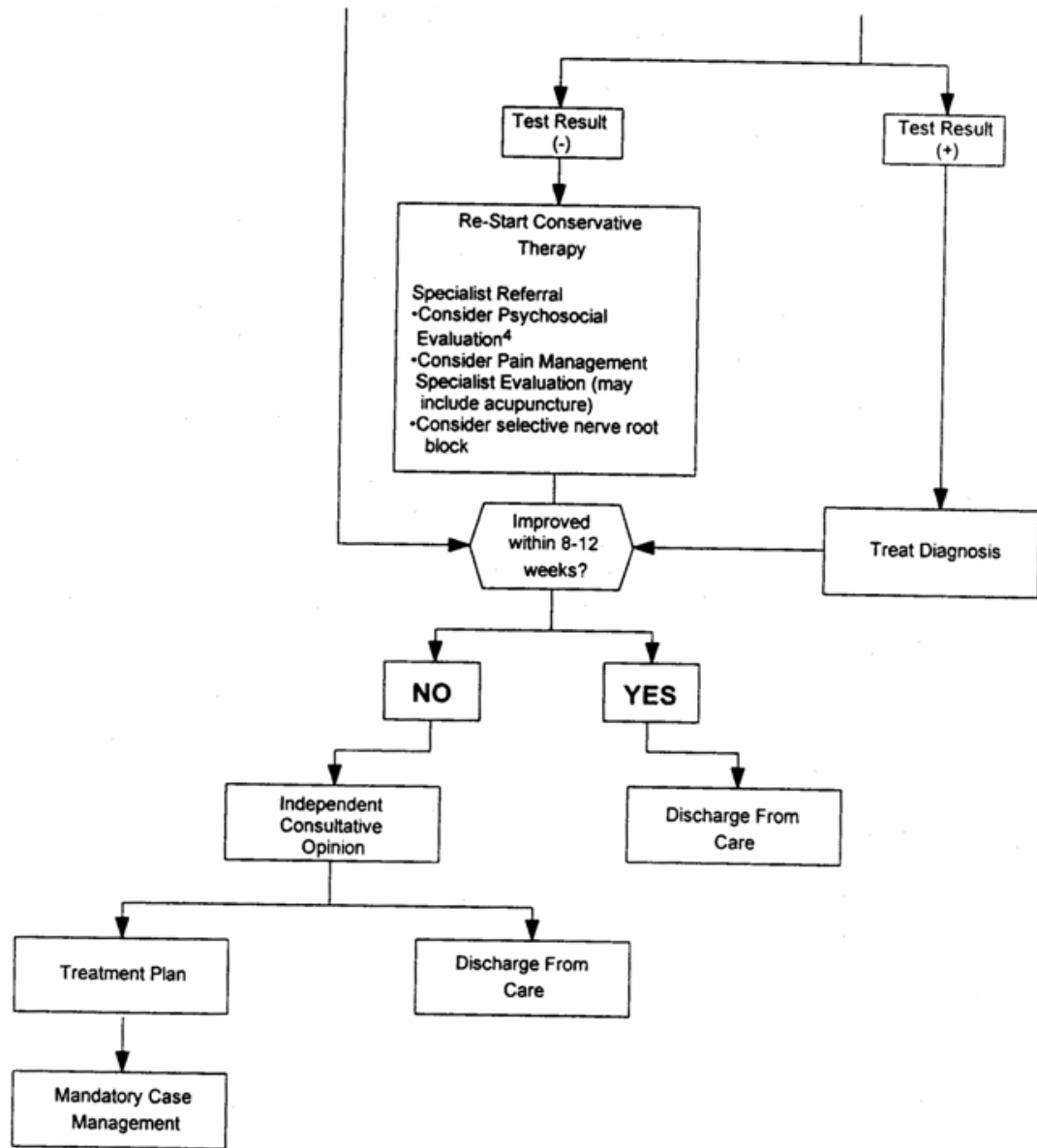
EXHIBIT 3

CARE PATH 1

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.



1, 2, 3, 4 See Addendum to Care Paths



ICD-9 CODES

- 728.0
- 728.85
- 739.0
- 739.1
- 847.0
- 847.9
- 922.3
- 922.31
- 953.0

⁴ See Addendum to Care Paths

CARE PATH 1

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EXHIBIT 10

ADDENDUM TO CARE PATHS

1. 2. (No change.)

3. Spinal Manipulation

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.

When findings suggest progressive or severe neurologic deficits, an appropriate diagnostic assessment to rule out serious neurologic conditions is indicated before beginning manipulation 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.)

EXHIBIT 11
STATE OF NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
DECISION POINT REVIEW/PRECERTIFICATION IMPLEMENTATION REPORT

COMPANY NAME _____
 NAIC # _____ GROUP # _____ NO. OF COMPANIES IN GROUP _____
 REPORT FOR _____, _____
 (MONTH) (YEAR)

DECISION POINT REVIEW REQUESTS	Month Totals		Denial Reason				Month Total	Modified Reason			
	# Received	# Denied	A	B	C	D	# Modified	A	B	C	D
Treatment											
Testing											
PRECERTIFICATION REQUESTS											

	MONTH TOTAL
NUMBER OF PHYSICAL EXAMINATIONS SCHEDULED PURSUANT TO N.J.A.C. 11:3-4.7(b)(2)	
NUMBER OF PHYSICAL EXAMINATIONS COMPLETED PURSUANT TO N.J.A.C. 11:3-4.7(b)(2)	
NUMBER OF INTERNAL APPEAL REQUESTS RECEIVED	
NUMBER OF INTERNAL APPEAL REQUESTS RESULTING IN DENIAL OF INITIAL DETERMINATION	
NUMBER OF INTERNAL APPEAL REQUESTS RESULTING IN MODIFICATION OF INITIAL DETERMINATION	

Reasons for Denial /Modification*

- A - Insufficient Information supplied by provider
- B - Level of treatment not consistent with diagnosis
- C - Patient has reached maximum improvement
- D - Other (give brief descriptions below)

**"Medically unnecessary" is too general. Reason should be more specific

DENIED MEANS THAT THE TEST OR TREATMENT WAS FOUND NOT TO BE REIMBURSABLE UNDER PIP

MODIFIED MEANS THE TEST OR TREATMENT APPROVED WAS DIFFERENT THAN THAT REQUESTED BY THE PROVIDER

Click here for image