INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS
(Text of Rule effective until September 4, 2004)

11:3-4.1 Scope and purpose

(a) This subchapter implements the provisions of N.J.S.A. 39:6A-3.1, 39:6A-4 and 39:6A-4.3 by identifying the personal injury protection medical expense benefits for which reimbursement of eligible charges will be made by automobile insurers under basic and standard policies and by motor bus insurers under medical expense benefits coverage.

(b) This subchapter applies to all insurers that issue policies of automobile insurance containing PIP coverage and policies of motor bus insurance containing medical expense benefits coverage.

(c) This subchapter shall apply to those policies that are issued or renewed on or after March 22,1999.

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.

"Basic automobile insurance policy" or "basic policy" means those private passenger automobile insurance policies issued in accordance with N.J.S.A. 39:6A-3.1and N.J.A.C. 11:3-3.

"Clinically supported" means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
2. Physically examined the patient including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests;
3. Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

"Decision point" means those junctures in the treatment of identified injuries where a decision must be made about the continuation or choice of further treatment. Decision point also refers to a determination to administer one of the tests listed in N.J.A.C. 11:3-4.5(b).

"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.

"Eligible charge" means the treating health care provider's usual, customary and reasonable charge or the upper limit of the medical fee schedule as found in N.J.A.C. 11:3-29.6, whichever is lower.

"Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident.

"Health care provider" or "provider" means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to:

1. A hospital or health care facility that is maintained by State or any political subdivision;
2. A hospital or health care facility licensed by the Department of Health and Senior Services;
3. Other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiological and diagnostic testing, free-standing emergency clinics or offices, and private treatment centers;
4. A nonprofit voluntary visiting nurse organization providing health care services other than a hospital;
5. Hospitals or other health care facilities or treatment centers located in other States or nations;
6. Physicians licensed to practice medicine and surgery;
7. Licensed chiropractors;
8. Licensed dentists;
9. Licensed optometrists;
10. Licensed pharmacists;
11. Licensed chiropodists (podiatrists);
12. Registered bioanalytical laboratories;
13. Licensed psychologists;
14. Licensed physical therapists;
15. Certified nurse mid-wives;
16. Certified nurse practitioners/clinical nurse-specialist;
17. Licensed health maintenance organizations;

18. Licensed orthotists and prosthetists;
19. Licensed professional nurses;
20. Licensed occupational therapists;
21. Licensed speech-language pathologists;
22. Licensed audiologists;
23. Licensed physicians assistants;
24. Licensed physical therapy assistants;
25. Licensed occupational therapy assistants; and
26. Providers of other health care services or supplies, including durable medical goods.

"Identified injury" means those injuries identified by the Department in the subchapter Appendix as being suitable for medical treatment protocols in accordance with N.J.S.A. 39:6A-3.1a and 39:6A-4a.

"Medical expense" means the reasonable and necessary expenses for treatment or services rendered by a provider, including medical, surgical, rehabilitative and diagnostic services and hospital expenses and reasonable and necessary expenses for ambulance services or other transportation, medication and other services, subject to limitations as provided for in the policy forms that are filed and approved by the Commissioner.

"Medically necessary" or "medical necessity" means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

1. 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;
2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
3. Does not include unnecessary testing or treatment.

"Non-medical expense" means charges for those:

1. Products and devices, not exclusively used for medical purposes or as durable medical equipment, such as any vehicles, durable goods, equipment, appurtenances, improvements to real or personal property, fixtures; and
2. Services and activities such as recreational activities, trips and leisure activities.

"Pre-certification" means a program, described in policy forms in compliance with these rules, by which the medical necessity of certain diagnostic tests, medical treatments and procedures are subject to prior authorization, utilization review and/or case management.

"Standard automobile insurance policy" or "standard policy" means a private passenger automobile insurance policy issued in accordance with N.J.S.A. 39:6A-4.

11:3-4.3 Personal injury protection benefits applicable to basic and standard policies

(a) Personal injury protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident up to the limits set forth in the policy and in accordance with this subchapter.

(b) Personal injury protection coverage shall only provide reimbursement for clinically supported necessary non-medical expenses that are prescribed by a treating medical provider for a permanent or significant brain, spinal cord or disfiguring injuries.

11:3-4.4 Deductibles and co-pays

(a) Each insurer shall offer a standard $250.00 deductible and 20 percent copayment on medical expense benefits payable between $250.00 and $5,000.

(b) Each insurer shall also offer, at appropriately reduced premiums, the option to select medical expense benefit deductibles of $500.00, $1,000, $2,000 and $2,500 in accordance with the following provisions:

1. Any medical expense deductible elected by the named insured shall apply only to the named insured and any resident relative in the named insured's household, who is not a named insured under another automobile policy and not to any other person eligible for personal injury protection benefits required to be provided in accordance with N.J.S.A. 39:6A-3.1and 39:6A-4;

2. Premium credits calculated and represented as a percentage of the applicable premium shall be provided for each deductible. The premium percentage shall be uniform by filer on a statewide basis; and

3. The deductible option elected by the named insured shall continue in force as to subsequent renewal or replacement policies until the insurer or its authorized representative receives a properly executed coverage selection form to eliminate or change the deductible.

(c) All deductibles and co-pays in (a) and (b) above shall apply on a per accident basis.

(d) Notwithstanding (a) and (b) above, an insurer may offer alternative deductible and co-pay options as part of an approved pre-certification program pursuant to N.J.A.C. 11:3-4.8

(e) An insurer may require that the insured advise and inform the insurer about the injury and the claim. This requirement may include the production of information from the insured 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) For private passenger automobiles insured under a commercial automobile insurance policy where no natural person is a named insured, insurers shall only provide personal injury protection with medical expense benefits coverage in an amount not to exceed $250,000 per person, per accident, with the deductible and copayment amount set forth in (a) above.

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. (Reserved)
2. Spinal diagnostic ultrasound;
3. Iridology;
4. Reflexology;
5. Surrogate arm mentoring;
6. Surface electromyography (surface EMG);
7. (Reserved); and
8. Mandibular tracking and stimulation.

(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. Somasensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex Study are reimbursable when used to evaluate neuropathies and/or signs of atrophy, but not within 21 days
following the traumatic injury.

3. Electroencephalogram (EEG) when used to evaluate head injuries, where there are clinically supported findings of an altered level of sensorium and/or a suspicion of seizure disorder. This test, if indicated by clinically supported findings, can be administered immediately following the insured event. When medically necessary, repeat testing is not normally conducted more than four times per year.

4. Videofluroscopy only when used in the evaluation of hypomobility syndrome and wrist/carpal hypomobility, where there are clinically supported findings of no range or aberrant range of motion or dysmmetry of facets exist. This test should not be performed within three months following the insured event and follow up tests are not normally appropriate.

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. Dynatron/cyber station/cybex when used to evaluate muscle deterioration or atrophy. These tests should not be performed within 21 days of the insured event and should not be repeated if results are negative. Repeat tests are not appropriate at less than six months intervals.

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 in (b) above, are intended to recognize that no single rule can replace the good faith educated judgment of a health care provider. 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 health care provider. 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) Except as provided in (e) below, a determination to administer any of the tests in (b) above shall be subject to decision point review pursuant to. N.J.A.C. 11:3-4.7.

(e) The requirements of (b) and (d) above shall not apply to diagnostic tests administered during emergency care.

(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.

11:3-4.6 Medical protocols

(a) Pursuant to N.J.S.A. 39:6A-3.1 and 39:6A-4, the Commissioner designates the care paths,

set forth in the subchapter Appendix incorporated herein by reference, as the standard course of medically necessary treatment, including diagnostic tests, for the identified injuries.

(b) Where the care path indicates a decision point either by a hexagon in the care path itself or by reference in the text to a second opinion, referral for a second independent consultative medical opinion, development of a treatment plan or mandatory case management, the policy shall provide for a decision point review in accordance with N.J.A.C. 11:3-4.7.

(c) Treatments that vary from the care paths shall be reimbursable only when warranted by reason of medical necessity.

(d) The care paths do not apply to treatment administered during emergency care.

11:3-4.7 Decision Point Review

(a) Insurers shall file for approval policy forms that provide a plan for the timely review of treatment of identified injuries at decision points and for the approval of the administration of the diagnostic tests in N.J.A.C. 11:3-4.5(b).

(b) The decision point review plan shall meet the following requirements:

1. The plan shall include procedures for the injured person or his or her designee to provide prior notice to the insurer or its designee together with the appropriate clinically supported findings that additional treatment or the administration of a test in accordance with N.J.A.C. 11:3-4.5(b) is medically necessary, as follows:

i. The prompt review of the notice and supporting materials submitted by the provider and authorization or denial of reimbursement for further treatment or tests;

ii. The scheduling of a physical examination of the injured person in accordance with (b)2 below where the notice and supporting materials and other medical records if requested, are not sufficient to authorize or deny reimbursement of further treatment or tests; and

iii. Any denial of reimbursement for further treatment or tests shall be based on the determination of a physician.

2. A physical examination of the injured party as part of a decision point review shall be conducted as follows:

i. The insurer shall notify the injured person or his or her designee that a physical examination is required;

ii. The physical examination shall be scheduled within seven calendar days of receipt of the notice in (b)1 above unless the injured person agrees to extend the time period;

iii. The medical examination shall be conducted by a provider in the same discipline as the treating provider;

iv. The medical examination shall be conducted at a location reasonably convenient to the injured person;

v. The treating provider or injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the

medical examination. The requested records shall be provided no later than the time of the examination; and

vi. The insurer shall notify the injured person or his or her designee whether reimbursement for further treatment or tests is authorized as promptly as possible but in no case later than three days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

3. The plan may provide that failure to notify the insurer as required in the plan; failure to provide medical records; or failure to appear for the physical examination scheduled in accordance with b(2) above shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical goods and non-medical expenses that are incurred after notification to the insurer is required but before authorization for continued treatment or the administration of a test is made by the insurer. No insurer may impose the additional co-payment where the insurer received the required notice but failed to act in accordance with its approved decision point plan to authorize or deny reimbursement of further treatment or tests.

4. The plan shall avoid undue interruptions in a course of treatment.

5. Insurers are encouraged to provide decision point review plans that permit the treating provider to submit for review a comprehensive treatment plan so as to minimize the need for piecemeal review.

(c) All decision point review plans, including a pre-certification program filed and approved pursuant to N.J.A.C. 11:3-4.8 shall contain provisions for the disclosure of the procedures in the decision point review plan to injured persons and providers.

1. The information required to be disclosed pursuant to this subsection shall include a description of:

i. The financial responsibility of the injured person including co-payments and deductibles;

ii. The financial responsibility of the provider for providing treatment or administering tests without authorization from the insurer; and

iii. How authorization for treatment and the administration of tests may be obtained.

2. In addition to the description of the plan set forth in the policy form, the insurer shall provide any information necessary to comply with decision point review in accordance with this rule to the injured person, the provider, or both, promptly upon receiving notice of the claim.

(d) No decision point requirements shall apply within 10 days of the insured event. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

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.

(c) No precertification requirements shall apply within 10 days of the insured event.

(d) Precertification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or test.

(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. Any utilization decision to deny reimbursement for further testing or treatment because the treatment or diagnostic tests are not medically necessary, shall be made by a physician. In the case of treatment prescribed or provided by a dentist, the decision shall be by a dentist;

2. A utilization management decision shall not retrospectively deny payment for treatment provided when prior approval has been obtained, unless the approval was based upon fraudulent information submitted by the person receiving treatment or the provider; and

3. The utilization management program shall be available, at a minimum, during normal working hours to respond to authorization requests.

(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) A precertification plan may include provisions that require injured persons to obtain durable medical equipment directly from the insurer or its designee.

(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.