

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

### 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 and emergency personal injury protection coverage for which reimbursement of eligible charges will be made by automobile insurers under basic, standard and special automobile insurance 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, emergency personal injury protection 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.

"Ambulatory surgery facility" or "ambulatory surgical center" (ASC) means:

1. A surgical facility, licensed as an ambulatory surgery facility in New Jersey in accordance with N.J.A.C. 8:43A, in which ambulatory surgical cases are performed and which is separate and apart from any other facility license. (The ambulatory surgery facility may be physically connected to another licensed facility, such as a hospital, but is corporately, financially and administratively distinct, for example, it uses a separate tax-id number); or

2. A physician-owned single operating room in an office setting that is certified by Medicare.

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

“Days” means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours. Insurers shall set a close of business time in their Decision Point Review plans;

2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last

day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

3. Example: Decisions on treatment appeals shall be communicated to the provider no later than 10 days from the date the insurer acknowledges receipt to the provider. The insurer acknowledges receipt by facsimile transmission dated 3:00 P.M. on Wednesday, June 8. Day one of the 10-day period is Thursday, June 9. Since the 10th day would be Saturday, June 18, the insurer's decision is due no later than Monday, June 20.

"Decision point" means those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths where a decision must be made about the continuation or choice of further treatment. The determination whether to administer one of the tests listed in N.J.A.C. 11:3-4.5(b) is also a decision point for both identified and all other injuries.

"Decision point review" means the procedures in an insurer's approved decision point review plan for the insurer to receive notice and respond to requests for proposed treatment or testing at decision points.

"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.

"Emergency personal injury protection coverage" means the coverage provided by a Special Automobile Insurance Policy pursuant to section 45 of P.L. 2003, c.89.

"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.

"Insurer" means any person or persons, corporation, association, partnership, company, reciprocal exchange or other legal entity authorized or admitted to transact private passenger automobile insurance in this State, or any one member of a group of affiliated companies that transacts business in accordance with a common rating system. Insurer does not include an entity that is self-insured pursuant to N.J.S.A. 39:6-52. For purposes of communicating with insureds and providers concerning the administration of decision point review plans, "insurer" also means the insurer's PIP vendor.

"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.

"Network" means an entity other than an insurer that contracts with providers to render health care services or provide supplies at predetermined fees or reimbursement levels.

"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.

"Organized delivery system" (ODS) means an organized delivery system certified or licensed pursuant to N.J.S.A. 17:48H-1 et seq., N.J.A.C. 11:22-4 or N.J.A.C. 11:24B.

"PIP vendor" means a company used by an insurer for utilization management.

"Precertification" or "precertification request" means the procedures in an insurer's approved decision point review plan for the insurer to receive notice and respond to requests for listed 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.

"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.

"Standard professional treatment protocols" means evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals.

"Utilization management" means a system for administering some or all of an insurer's decision point review plan, including, but not limited to, receiving and responding to decision point review and precertification requests, making determinations of medical necessity, scheduling and performing independent medical examinations (IMEs), bill review and handling of provider appeals.

#### 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-3.1 and 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) An insurer may file policy language that waives the co-payment and deductible in (a) and

(b) above when the insured receives medical treatment from a provider that is part of an ODS that has contracted with the insurer or its PIP vendor. The insured shall not be required to elect to use the providers or facilities in such an ODS either at issuance of the policy or when the claim is made.

1. Upon receipt of notification of a claim, the insurer or its PIP vendor shall make available to the insured information about physicians and facilities in any ODS with which it has a contract.

i. The information shall include a notice that the insured is not required to use the providers or facilities of an ODS with which the insurer or its PIP vendor has contracted and indicate that if the insured chooses to receive covered services from such providers or facilities, the deductible and copayments in (a) and (b) above would not apply.

ii. The information shall also indicate that the insured may seek treatment from providers and facilities that are not part of an ODS with which the insurer or its PIP vendor has contracted, in which case the deductible and copayments in (a) and (b) above would apply.

2. The actual ODS access fee or 25 percent of the reduction in charges resulting from the use of the ODS provider, whichever is less, may be included within the policy limits for any single bill from an in-network provider in the ODS with billed charges of \$10,000 or more.

Example: A \$10,000 charge is reduced by the ODS contract with the insurer by 45 percent to \$5,500. The insurer could include the ODS access fee or \$1,125 (25 percent of the \$4,500 reduction), whichever is less, within the policy limits.

(e) Failure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment not to exceed 50 percent of

the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

Example: Assume that all days are business days and the insurer's Decision Point Review Plan gives the insurer three days to respond to decision point review and precertification requests. By the terms of the insurer's Decision Point Review Plan, a treating medical provider is required to make a decision point review request on day 21 of treatment (time notification was required). The provider does not give the required notification in a timely manner but continues to treat the patient. The provider then makes the notification and it is received by the insurer on day 35 (time proper notification made). The insurer responds on day 38 that the treatment can proceed (time for insurer to respond). Assuming that the treatment made between day 21 and 38 was medically necessary, it is subject to the 50 percent co-payment.

1. 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 review plan to request further information, modify or deny reimbursement of further treatment, diagnostic tests or durable medical equipment.

(f) 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).

(g) An insurer may impose an additional co-payment not to exceed 30 percent of the eligible charge for failure to use an approved network pursuant to N.J.A.C. 11:3-4.8 for the medically necessary non-emergency benefits listed in N.J.A.C. 11:3-4.8(b).

(h) For the purpose of the co-payments permitted in (e), (f) and (g) above, the percentage reduction shall be applied to the amount that the insurer would otherwise have paid to the insured or the provider after the application of the provisions of N.J.A.C. 11:3-29. Insurers may apply the co-payments and deductibles in (a) through (g) above in any order, provided that they use the same order of application for all insureds. Upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall make its co-payment and deductible application methodology available to the insured and the treating medical provider upon request.

(i) 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. Videofluoroscopy 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 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. 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 plans

(a) No insurer shall impose the co-payments permitted in N.J.A.C. 11:3-4.4(e), (f) and (g) unless it has an approved decision point review plan.

1. Initial decision point review plan filings and amendments to approved plans shall be submitted to the Department through the use of the NAIC electronic filing system SERFF (System for Electronic Rate and Form Filing).

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

(c) A decision point review plan filing shall include the following information:

1. Identification of any PIP vendor with which the insurer has contracted and a copy of the contract between the insurer and the PIP vendor. No insurer shall contract with a PIP vendor unless the vendor is registered with the Department pursuant to N.J.A.C. 11:3-4.7A;

2. Identification of any specific medical procedures, treatments, diagnoses, diagnostic tests, other services or durable medical equipment that are subject to precertification. The inclusion of precertification requirements in a decision point review plan is optional. The medical procedures, treatments, diagnoses, diagnostic tests or durable medical equipment required to be precertified shall be those that the insurer has determined may be subject to overutilization and that are not already subject to decision point review. The insurer shall not require the precertification of a new-patient evaluation and management visit that is necessary for the provider to develop the plan of care that is incorporated into a precertification request for treatment or diagnostic testing;

3. Copies of the informational materials described in (d) below and an explanation of how the insurer will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim.

4. Procedures for the prompt review, not to exceed three business days, of decision point review and precertification requests by insureds or providers. All determinations on treatments or tests shall be based on medical necessity and shall not encourage over or underutilization of benefits. Denials of decision point review and precertification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist;

5. Procedures for the scheduling of physical examinations pursuant to (e) below;

6. [Agency Note: This requirement is not operative until November 5, 2013.] An internal appeals procedure that meets the requirements of N.J.A.C. 11:3-4.7B;

7. Reasonable restrictions on the assignment of benefits pursuant to N.J.A.C. 11:3-4.9(a);

8. Reasonable restrictions on what types of providers may submit decision point review requests; and

9. An explanation of the insurer's restrictions on assignment of benefits, if any.

(d) The informational materials for policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the information in (d)1 through 9 below. In order to make the requirements of this subchapter easier for insureds and providers to use, the Commissioner may by Order require the use of uniform forms, layouts and language of information materials.

1. How to contact the insurer or vendor to submit decision point review/precertification requests including the telephone, facsimile numbers, e-mail addresses or through a website. The insurer or its vendor shall be available, at a minimum, during normal working hours to respond to decision point review/precertification requests;

2. An explanation of the decision point review process including a list of the identified injuries and the diagnostic tests in N.J.A.C. 11:3-4.5(b). The materials shall include copies of the Care Paths or indicate how copies may be obtained;

3. A list of the medical procedures, treatments, diagnoses, diagnostic tests, durable medical equipment or other services that require precertification, if any;

4. An explanation of how the insurer will respond to decision point review/precertification requests, including time frames. The materials should indicate that:

i. Telephonic responses will be followed up with a written authorization, denial or request for more information within three business days;

5. An explanation of the insurer's option to require a physical examination pursuant to (e) below;

6. An explanation of the penalty co-payments imposed for the failure to submit decision point review/precertification requests where required in accordance with N.J.A.C. 11:3-4.4(e);

7. An explanation of the insurer's voluntary network or networks for certain types of testing, durable medical equipment or prescription drugs authorized by N.J.A.C. 11:3-4.8, if any;

8. An explanation of the alternatives available to the provider if reimbursement for a proposed treatment, diagnostic test or durable medical equipment is denied or modified, including insurer's internal appeal process and how to use it; and

9. An explanation of the insurer's restrictions on assignment of benefits, if any.

(e) A physical examination of the injured party shall be conducted as follows:

1. The insurer shall notify the injured person or his or her designee that a physical examination is required to determine the medical necessity of further treatment, diagnostic tests or durable medical equipment. An insurer shall include reasonable procedures for the notification of the injured person and the treating medical provider where reimbursement of further treatment, diagnostic testing or durable medical equipment will be denied for failure to appear at scheduled medical examinations.

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

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

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

5. The 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 at the time of the examination or before.

6. The insurer shall notify the injured person or his or her designee and the treating medical provider whether it will reimburse for further treatment, diagnostic tests or durable medical equipment as promptly as possible but in no case later than three business 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.

7. Insurers may include in their decision point review plan a procedure for the denial or reimbursement for treatment, diagnostic testing or durable medical equipment after repeated unexcused failure to attend a scheduled physical examination. The procedure shall provide for adequate notification of the insured and the treating provider of the consequences of failure to attend the examination.

(f) In administering decision point review and precertification, insurers shall avoid undue interruptions in a course of treatment. As part of their decision point review plans, insurers may include provisions that encourage providers to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries to minimize the need for piecemeal review. An agreed comprehensive treatment plan may replace the requirements for notification to the insurer at decision points and for treatment, diagnostic testing or durable medical equipment requiring precertification. In addition, the insurer may provide that reimbursement for treatment, diagnostic tests or durable medical equipment consistent with the agreed plan will be made without review or audit.

(g) An insurer shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless

the request involved fraud or misrepresentation, as defined in N.J.A.C. 11:16-6.2, by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

#### 11:3-4.7A PIP vendor registration requirements

(a) No company shall perform utilization management services for an insurer unless registered as a PIP vendor pursuant to this section.

(b) Any PIP vendor working for an insurer prior on November 5, 2012 shall file for registration by February 3, 2013.

(c) Application for registration shall be made on a form prescribed by the Commissioner, which can be found on the Department's website at

<http://www.state.nj.us/dobi/pipinfo/aicrapg.htm>.

(d) The application shall be accompanied by the applicant's business plan, which shall include the following information:

1. A statement generally describing the applicant, its facilities, personnel, and the services to be offered by the PIP vendor;

2. The name of its medical director(s) licensed to practice as physician(s) in New Jersey and a detailed explanation about how the medical director(s) provide(s) oversight of determinations of medical necessity;

3. The name and contact information of a person at the vendor who is designated to receive and handle complaints and inquiries from the Department;

4. Information on activities undertaken or to be undertaken in New Jersey by the company;

5. A demonstration of the applicant's capability to provide a sufficient number of experienced and qualified personnel in the areas of PIP utilization management, and information on staffing levels, including, but not limited to, training, hiring requirements, experience of staff in general and with PIP utilization management in particular;

6. A statement about whether the applicant is licensed or certified as an entity that has networks as that term is defined in N.J.A.C. 11:3-4.8(a) or accredited by nationally recognized accrediting agencies such as URAC (<http://www.urac.org/>) in Health Utilization Management; and

7. A copy of the applicant's certificate of incorporation.

(e) The application shall also be accompanied by the following information concerning how the applicant will handle PIP utilization management:

1. The vendor's clinical review criteria and protocols. The information shall include a descriptive flow chart of its processes used in decision-making, which shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers, and be based upon generally accepted medical standards and standard professional treatment protocols;

2. A copy of the vendor's policies and procedures that demonstrate that the vendor is handling utilization management in accordance with N.J.A.C. 11:3-4, 5 and 29; and

3. The mechanisms it uses to detect underutilization and overutilization of services.

(f) A PIP vendor that arranges the physical examinations of injured parties pursuant to N.J.A.C. 11:3-4.7(e) shall submit the criteria it uses to select providers to be on the vendor's panel of examining providers, how it evaluates the quality of an examining provider's



examination report and how it avoids conflicts of interest when examinations are ordered and scheduled.

(g) Two copies of the information in (a) through (f) above shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance  
Office of Property and Casualty  
P.O. Box 325  
Trenton, NJ 08625-0325

(h) The Department shall advise the applicant if the application is incomplete not later than 60 days after receipt of the application. Notice to the applicant that the application is incomplete shall specify the missing items or information. The Department shall disapprove an incomplete application if the requested information is not provided within 30 days of the notification to the applicant. If the Department does not notify the applicant of missing items or information within 60 days of receipt, the application shall be deemed complete.

(i) The Commissioner shall approve an application for registration if he or she finds that the applicant has demonstrated the ability to perform services in a manner that meets the requirements of this subchapter.

(j) The Commissioner may deny an application for registration as a PIP vendor if he or she finds that any of standards established by this subchapter have not been met or for any other reasonable grounds.

1. If the application for registration is denied, the Commissioner shall notify the applicant in writing of the reasons for the denial.

2. When the Department denies an application for registration, the applicant may request a hearing within 30 days of receipt of the denial by submitting a request in writing to the

address in (g) above setting forth, with specificity, the reasons that the applicant disputes the Department's denial notice.

(k) Registration shall be effective for a period of two years. Registered PIP vendors shall reapply for registration 90 days prior to expiration by submitting the information in (d) through (f) above showing changes to the items previously submitted.

(l) All data or information in the PIP vendor's application for registration and the vendor's contract with the insurer required to be submitted pursuant to N.J.S.A. 11:3-4.7(c)1 above shall be confidential and shall not be disclosed to the public, except as follows:

1. The PIP vendor's certificate of incorporation;
2. The PIP vendor's address;
3. The names of the PIP vendor's officers and directors, or the individuals in the organization responsible for the administration of utilization management including the medical director(s); and
4. The date of registration of the PIP vendor and date that registration expires.

(m) The Commissioner may suspend or revoke the registration of a PIP vendor upon finding that the PIP vendor no longer meets the standards set forth in this subchapter; that PIP utilization review services are not being provided in accordance with the requirements of this subchapter; or that the registration was granted based on false or misleading information.

1. Proceedings to revoke or suspend the registration shall be conducted pursuant to N.J.A.C. 11:17D.

2. Upon request of the PIP vendor for a hearing, the matter shall be transferred to the Office of Administrative Law for a hearing conducted pursuant to the Administrative Procedure

Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:3-4.7B Internal appeals procedure [Agency Note: This rule will not be operative until November 5, 2013.]

(a) The internal appeals process shall permit a provider who has been assigned benefits pursuant to N.J.A.C. 11:3-4.9 or has a power of attorney from the insured to submit additional information and have a rapid review of an adverse decision by the insurer.

(b) An adverse decision is any determination by the insurer with which the provider does not agree and includes, but is not limited to:

1. Determinations of medical necessity for treatment or testing requested by the provider via a properly completed Decision Point Review/Precertification Request;

2. Disputes about whether the insured's injuries were caused by a motor vehicle accident;

3. Disputes between the insurer and the provider concerning the time of notification, receipt, and submission of Decision Point Review/Precertification requests or other notifications required by N.J.A.C. 11:3-4;

4. Disputes about the imposition of the deductibles and copayments in N.J.A.C. 11:3-4.4;

5. A provider's claim that a payment from the insurer is overdue pursuant to N.J.S.A. 39:6A-5g;

6. Disputes involving a provider's usual, customary and reasonable fee; or

7. Disputes about coding, including, but not limited to: which HCPCS, CPT or CDT code properly represents the service performed, sometimes known as downcoding; the use of unlisted codes; and the application of the NCCI edits.

(c) There are two types of internal appeals:

1. Treatment appeals about the medical necessity of future treatment or testing that was requested by the provider on a properly completed Decision Point Review/Precertification Request; and

2. Administrative appeals for all other types of adverse decisions.

(d) All appeals shall be filed using the form established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). The appeal form and any supporting documentation shall be submitted by the provider to the address or fax number designated for appeals in the insurer's DPR plan.

1. The insurer's DPR plan shall include a regular mailing address and a fax number for filing appeals. The insurer may also establish a procedure in its DPR plan for the submission and acknowledgment of appeals by electronic means.

2. The appeal form from the provider must reference the correct insurance claim number, date of loss and patient name, clearly identify the adverse decision that is the basis for the appeal and must have been sent to the address or fax number designated for appeals in the insurer's DPR plan.

3. For appeals, acknowledgments and decisions sent by regular mail, it shall be the responsibility of the sender to provide proof that the item was mailed.

4. A confirmation generated by a fax machine or computer that shows the time, date, and fax number of the sending and receiving machine shall be evidence that the appeal, acknowledgment or decision was faxed and received. The insurer must accept fax confirmations.

5. For appeals, acknowledgments and decisions sent by regular mail, the postmark date shall be considered as the date the appeal, decision or acknowledgment was mailed.

(e) A treatment appeal shall be submitted no later than five business days after the provider has received notice of the adverse decision that is the basis for the appeal.

1. Treatment appeals that are not submitted in accordance with the time frame in (e) above may not be submitted as administrative appeals. If a provider misses the deadline to submit a treatment appeal, he or she may submit another decision point review request for the treatment or testing in accordance with the insurer's DPR plan.

(f) Nothing in this section shall be construed so as to require reimbursement of tests or treatments that are not medically necessary or to prevent the application of the penalty co-payments in N.J.A.C. 11:3-4.4(e).

(g) An administrative appeal shall be submitted within 180 days of the adverse decision that is the basis for the appeal.

(h) The insurer shall acknowledge receipt of the appeal by regular mail, fax or electronic means on a form established by the Department by Order pursuant to N.J.A.C. 11:3-4.7(d).

1. The receipt of treatment appeals shall be acknowledged within three business days.

2. The receipt of administrative appeals shall be acknowledged within five business days.

3. Appeals received without the information required by (d)2 above shall be acknowledged in the time frames set forth above as “Incomplete” and with the missing or incorrect information noted. Appeals received after the deadlines in (e) and (g) above shall be acknowledged as “Late Appeals.” An incomplete filing or late appeal does not constitute an appeal pursuant to this subchapter.

(i) The insurer shall conduct a review of the appeal and notify the provider of its decision by fax, mail or electronic means. The insurer may contact the provider by telephone but must follow up with a written decision that is transmitted as described (h) above.

1. Decisions on treatment appeals shall be received by the provider who submitted the appeal no later than 10 days from the date the provider receives the acknowledgment of the appeal.

2. Decisions on administrative appeals shall be received by the provider who submitted the appeal no later than 30 days from the date the provider receives the acknowledgment of the appeal.

3. An insurer may determine that a physical examination pursuant to N.J.A.C. 11:3-4.7(e) is necessary to respond to the appeal. In that case the time periods in (i)1 and 2 above shall start after the examination has been conducted and the report received.

(j) Pursuant to N.J.A.C. 11:3-5.6(a)2, a provider acting on assignment or the holder of a power of attorney from the insured must have filed an internal appeal prior to filing for alternate dispute resolution pursuant to N.J.A.C. 11:3-5. The demand for arbitration must be accompanied by the internal appeal decision or proof that the appeal was filed. The rules of the dispute resolution administrator shall set forth how such proof shall be submitted.

1. The rules of the dispute resolution administrator shall include penalties for providers and their attorneys who make arbitration demands without having exhausted the internal appeals process.

(k) An insurer that fails to respond to an internal appeal filed in accordance with (a) through (i) above shall lose the right to raise defenses in an arbitration on the issue that was the subject of the appeal. However, the insurer can raise other valid and relevant defenses in the arbitration. Example: A provider makes a decision point review request for treatment, which is denied by the insurer as not being medically necessary. The provider appeals the decision in accordance with the procedures in this subchapter. The insurer fails to respond to the appeal and the provider makes a demand for arbitration. By failing to respond to the appeal, the insurer loses the right to argue that the treatment requested in the Decision Point Review was not medically necessary. However, the insurer is not precluded from raising other defenses at the arbitration proceeding.

#### 11:3-4.8 Voluntary networks

(a) No insurer shall file a decision point review plan utilizing a voluntary network or networks unless the network is a health maintenance organization licensed pursuant to N.J.S.A. 26:2J-1 et seq.; or approved by the Department as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37 and 11:24A-4.10; or approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6; or is licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 and 11:24B.

(b) Voluntary networks may be offered for the provision of the following types of non-emergency benefits only:

1. Magnetic Resonance Imagery;

2. Computer Assisted Tomography;
3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, H-reflex and nerve conduction velocity (NCV) tests performed together by the treating physician;
4. Durable medical equipment with a cost or monthly rental in excess of \$ 50.00;
5. Prescription drugs; or
6. Services, equipment or accommodations provided by an ambulatory surgery facility.

(c) Insurers that offer voluntary networks either directly or through a PIP vendor shall meet the following requirements:

1. The insurer shall notify all insureds upon application for and issuance of the policy and upon renewal of the types of benefits for which it has voluntary networks. Use of the network by the insured is voluntary but bills for out-of-network services or equipment are subject to the penalty deductibles set forth in N.J.A.C. 11:3-4.4(g).

2. Upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall make available to the insured and the treating medical provider information about approved networks and providers in the network, including addresses and telephone numbers. Insureds shall be able to choose to go to any provider in the network.

(d) An insurer offering a voluntary network or networks directly or through a PIP vendor shall submit the following information to the Department with its Decision Point Review Plan:

1. A narrative description of the benefits to be offered through the network or networks;



2. The identity and a description of the network and the specific services or supplies to be provided by the network or networks;

3. A description of the procedures by which benefits may be obtained by persons using the network; and

4. A statement of how the network meets the requirement of (a) above.

(e) Any voluntary network used by an insurer pursuant to this subchapter shall agree to disclose to a participating provider, upon written request, a list of all the clients or other payers that are entitled to a specific rate under the network's contract with the participating provider.

#### 11:3-4.9 Assignment of benefits; public information

(a) Pursuant to N.J.S.A. 39:6A-4, an insured may only assign benefits and duties under the policy to a provider of service benefits. Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits and duties under the policy, consistent with the efficient administration of the coverage and the prevention of fraud. Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:

1. A requirement that as a condition of assignment, the provider agrees to follow the requirements of the insurer's decision point review plan for making decision point review and precertification requests; and/or

2. A requirement that as a condition of assignment, the provider shall hold the insured harmless for penalty co-payments imposed by the insurer based on the provider's failure to follow the requirements of the insurer's Decision Point Review Plan.

3. A requirement that as a condition of assignment, the provider agrees to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

(b) Insurers shall file policy language requiring that providers who are assigned benefits by the insured or have a power of attorney from the insured make an internal appeal pursuant to N.J.A.C. 11:3-4.7B prior to making a request for dispute resolution in accordance with N.J.A.C. 11:3-5.

(c) 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 (Reserved)