INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Proposed New Rules: N.J.A.C. 11:3-4

Proposal Number: PRN 1998-425.

PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

Authorized By: Elizabeth Randall, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1 and 17:1-15e and P.L. 1998, c.21 and c.22 (N.J.S.A. 39:6A-3.1 and 39:6A-4).

Submit comments by October 8, 1998 to:
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The agency proposal follows:

Summary

The Automobile Insurance Cost Reduction Act (the "Act"), P.L. 1998, c.21, enacted May 19, 1998, substantially revises the statutory requirements governing the provision of private passenger automobile insurance in this State. These revisions include: changes to the definition of the benefits available under the medical expense benefits of the personal injury protection ("PIP") coverage; provision for the establishment of treatment and diagnostic standards against which the medical necessity of treatments reimbursable under PIP medical expense benefits coverages will be measured; provision for the creation of two insurance coverage options, a basic policy pursuant to N.J.S.A. 39:6A-3.1 and a standard policy pursuant to N.J.S.A. 39:6A-4; a provision for cost containment of medical expense benefits through a revised dispute resolution proceeding including utilization review where appropriate by a medical review organization; revisions to the lawsuit threshold for suits for pain and suffering; revisions to the definition of the benefits available under medical expense benefits coverages; the establishment of conditions for the use by insureds of auto body repair facilities outside of those with which an insurer may have a financial arrangement or network; and the creation of the Office of the Fraud Prosecutor to consolidate agencies that combat fraud.

These proposed rules establish standards for PIP benefits provided by the basic and standard auto insurance policies. The Act repeals the present description of PIP coverage and redefines it to mean and include medical expense benefits as provided in the policy and approved by the Commissioner in accordance with these rules.

These proposed new rules contain the definitions of the basic medical expense benefits provided by PIP coverage. The Act directs the Commissioner to establish protocols for the standard and appropriate treatment of injuries sustained in automobile accidents and incorporate a list of valid diagnostic tests that have been determined to be useful in the treatment of injuries from automobile accidents.

Among the changes to the statutes concerning PIP, the Act includes a definition of "medically necessary." The Act states generally that medically necessary treatment for injuries sustained in automobile accidents is reimbursable under PIP up to the policy limits and impliedly provides that unnecessary or inappropriate treatments or tests shall not be reimbursable from the PIP medical benefits coverage.

These changes to the medical expense benefits provided by PIP coverage will require significant changes to present practices of some physicians who provide care to injured motorists and PIP insurers that pay these claims. PIP will no longer automatically reimburse the cost of medical care provided to persons injured in auto accidents. Rather, reimbursement will be limited in accordance with the terms of the policy to medically necessary treatments, tests, services

and items of durable medical equipment (DME) as set forth in the policy and approved by the Commissioner consistent with the provisions of these rules.

The Legislature has determined that the cost of PIP benefits should be reduced more than 25 percent (see N.J.S.A. 17:29A-51a(1) and (4)). In proposing these rules, it is the Department's intent that this goal should be accomplished while maintaining the quality of care provided to injured motorists. The Department believes that these proposed rules will significantly reduce costs without seriously compromising the quality of care. For minor injuries, however, it is likely that costs may be significantly reduced while providing the injured with levels of care comparable to that provided for similar injuries sustained from causes other than automobile accidents.

A recent closed claim survey comparing the cost of care for automobile accident injuries in New Jersey and other states that have Personal Injury Protection coverage found that the average cost of a "whiplash" injury in New Jersey was $ 5,933, the highest of the states surveyed and more than twice the average cost of $ 2,879. In addition, New Jersey had the highest average length of treatment and the highest average number of doctor visits per claim. While these proposed rules will establish significant limits on PIP medical expense benefits compared to the present system, they are intended to address and balance the competing goals of reducing costs while providing essential, quality medical care.

As required by the Act, the Department has consulted with the professional licensing boards in the Division of Consumer Affairs of the Department of Law and Public Safety concerning the use of diagnostic tests in the treatment of injuries in auto accidents. A working committee of the professional boards recommended two lists, which are included in the proposed new rules.

The first is a list of tests that have been determined to be of little or no value in the treatment or evaluation of injuries in automobile accidents. PIP medical benefits coverage will not provide reimbursement for these tests. The second list sets forth those diagnostic tests that have been determined to have value for which the working committee has recommended specific criteria and/or restrictions on their use. The restrictions may include injuries for which the tests are not appropriate, limited circumstances under which it is appropriate to re-administer a test and other factors. PIP medical benefits coverage will not provide reimbursement for these tests except when administered in accordance with the criteria and restrictions set forth in these proposed new rules. There are numerous medical diagnostic tests (that is, X-rays, blood tests) that have not been addressed by the boards or these rules. Administration of these tests is subject to the medical necessity standard in the proposed rules.

Additionally, the Act authorizes the Commissioner to set forth by regulation medical treatments and services to be reimbursable by the PIP medical expense benefits coverage, consistent with commonly accepted medical protocols and professional standards. The Department engaged a consultant to assist in developing the proposal and communicated with the professional licensing boards and the Department of Health and Senior Services, which consultations will continue until final rules are adopted. The initial group of these basic medical benefits were developed by the Department consultant in accordance with accepted professional standards. These standard treatments and practices are detailed as "care paths" based on the diagnosed injury and are set forth in the Appendix. The initial group of care paths set forth in these proposed rules includes treatments for certain back and neck injuries. Additional standard medical benefits in the form of additional care paths for other diagnosed injuries will be added by amendments to these rules as they are developed.

Medical care provided to persons injured in automobile accidents that is consistent with the care paths will be reimbursable by the PIP medical expense benefits coverage. Medical care that deviates from these care paths will not be reimbursable except by reason of specific medical necessity based upon adequate clinically supported findings in the particular case. Medical treatments or tests that are not medically necessary will not be reimbursable through PIP. Providers engaging in practices that result in the provision of unnecessary or inappropriate medical treatments and tests do so at their peril, since N.J.S.A. 39:6A-5.2g relieves the patient of responsibility to pay for unnecessary medical care.

No written rule can accurately prescribe or predict the precise course of medical treatment and tests necessary in every individual case. The Act recognizes that defining medical necessity involves subjective considerations, and these proposed new rules therefore provide for review of an injured person's condition at certain defined decision points when a determination must be made whether to proceed with certain treatments or tests. At these decision points, the rules generally provide that insurers have procedures for notice to be provided to the insurer that the provider considers further treatment or tests necessary, supported by appropriate clinical findings by a provider in the same medical discipline. If notice of the continuing treatment or diagnostic test is not provided to the insurer, then the treatment, if medically necessary, is subject to an additional copay of up to 50 percent.

These proposed rules also establish standards for pre-certification of medical care in conjunction with the treatment of automobile accident injuries. The Act permits auto insurers to issue policy forms that provide for pre-certification of certain treatments, diagnostic tests or other services, or items of DME. Pre-certification programs should include, but may be more extensive than, the decision point review specified above. Pre-certification is prohibited for emergency or initial care provided in the first 10 days after the accident. Insurers that file policy forms providing a pre-certification program will be required to provide adequate disclosure to the insured and to demonstrate that they have engaged a medical director who is a licensed physician to oversee pre-certification determinations and ensure that care will not be denied except by a physician.

In developing standards for both decision point review and pre-certification programs, the Department examined the patient protection standards of the Health Care Quality Act, P.L. 1997, c.192, (effective February 4, 1998). These standards generally require that information about coverage and procedures to authorize reimbursement be provided to the insured; that any decision to deny care be based on the findings of a physician; and that there be an opportunity to resolve disputes about the medical necessity or appropriateness of care for the patient by medical professionals independent of either party. The Department has included the first two principles in its standards for decision point review plans and pre-certification programs. With regard to an appeals process, the Department notes that the Act establishes an alternate dispute resolution process, with an opportunity for review of issues involving the medical necessity or appropriateness of medical care by an independent medical review organization. (See N.J.S.A. 39:6A-5.1 and 5.2) The Department will be proposing rules to implement these statutes shortly.

In order to encourage proper use of decision point review or pre-certification procedures, while recognizing the function of PIP to cover medically necessary care, these proposed rules provide that the policy form may include an additional copayment requirement of up to 50 percent for medically necessary tests or treatments when the injured party or provider fails to follow the required procedures. This additional copayment is comparable to those found in health insurance policies with pre-certification programs. If the test or treatment is not medically necessary or clinically supported, then, of course, no payment is required by the PIP insurer.

These proposed rules also establish the standard deductibles and copayments for PIP medical expense benefits. The rules provide that insurers shall offer a standard $ 250.00 deductible and 20 percent copayment on medical expense benefits payable between $ 250.00 and $ 5,000. Additionally, insurers shall offer optional higher medical expense benefit deductibles of $ 500.00, $ 1,000, $ 2,000 and $ 2,500. Except for the Act's new $ 2,000 deductible, the deductibles and copayment provisions are identical to those under present law. The deductibles apply on a per accident basis with the standard $ 250.00 deductible and 20 percent copayment applied if the insured does not choose a different option. Insurers may, however, offer alternative deductibles and copayment options as part of an approved pre-certification program. Special deductible/copayment programs (for example, no deductible or a small, per visit copayment) may facilitate use of pre-certification programs by consumers.

These proposed rules further provide that for private passenger automobile insurance issued on a commercial auto policy under which no natural person is a named insured, the insurer shall only provide the standard $ 250.00 deductible and 20 percent copayment up to $ 5,000. Typically, the named insured on most commercial insurance policies is a corporation or other business entity, and optional deductibles therefore have limited relevance on these policies. Standard copayment and deductible provisions in these policies will eliminate confusion and surprise regarding the benefits provided.

Finally, these proposed rules include a provision implementing an amendment to N.J.S.A. 39:6A-4c(2), set forth in P.L. 1997, c.151 (enacted June 30, 1977), which provides that PIP benefits shall not be assignable except to providers of service benefits, and in accordance with policy terms approved by the Commissioner. Revised policy provisions regarding assignments to health care providers may be appropriate as part of comprehensive revisions pursuant to the Act in order to promote the goals of the Act and the proposed new rules.

For example, it would be appropriate to require that the treating medical provider has the duty to initiate decision point or precertification review as a condition of assignment of benefits. The Department notes that PIP medical expense benefits are routinely assigned to providers and that providers in the health insurance system normally provide this function.

Proposed N.J.A.C. 11:3-4.1 sets forth the scope and purpose of these rules, which is to define personal injury protection medical expense benefits under the basic and standard policies offered by automobile insurers and medical expense benefits coverage provided by motor bus insurers. These rules will apply to policies issued or renewed 90 days after the effective date, when the coverage change provisions of P.L. 1998, c.21 take effect. These rules do not apply to health insurance where the insured has designated their health insurer as primary.

Proposed N.J.A.C. 11:3-4.2 sets forth definitions of terms used throughout the subchapter.

Proposed N.J.A.C. 11:3-4.3 sets forth the personal injury protection benefits applicable to the basic and standard auto insurance policies.

Proposed N.J.A.C. 11:3-4.4 describes applicable deductibles and copayments.

Proposed N.J.A.C. 11:3-4.5 sets forth restrictions on reimbursement for diagnostic tests that may be provided.

Proposed N.J.A.C. 11:3-4.6 establishes the medical protocols pursuant to the care paths set forth in the Appendix to the subchapter, and includes rules for their use.

Proposed N.J.A.C. 11:3-4.7 provides for decision point review in connection with certain diagnostic tests and medical protocols.

Proposed N.J.A.C. 11:3-4.8 sets forth rules regarding the use of pre-certification plans in conjunction with the administration of PIP reimbursement.

Proposed N.J.A.C. 11:3-4.9 permits reasonable policy restrictions on the assignment of PIP benefits.

The proposed Appendix to the subchapter sets forth the medical protocols in the format of care paths applicable for the treatment of certain diagnosed injuries.

Social Impact

These proposed new rules implement some of the provisions of the "Automobile Insurance Cost Reduction Act," particularly N.J.S.A. 39:6A-3.1 and 39:6A-4, which address the PIP medical expense benefits coverage in auto insurance policies. These proposed rules establish standards for PIP coverage provided in automobile and certain motor bus insurance policies. The rules are intended to implement the legislative intent to provide reasonable and necessary quality medical care to injured persons, while significantly reducing costs. The rules set forth standard medical protocols, diagnostic tests and standards for pre-certification programs so as to reduce or eliminate the costs associated with unnecessary or inappropriate medical treatment and tests. The rules thus serve to promote cost efficient provision of quality medical care to persons injured in automobile accidents.

Economic Impact

These proposed new rules will affect private passenger automobile insurers and insureds and the Department. In addition, there will be some derivative economic impact on those providing medical care to persons injured in automobile accidents.

Insurers will be required to prepare and file appropriate changes to their rating system, as required by the Act, in a manner consistent with the rules. These changes involve one-time capital costs, as well as modifications of policy underwriting and support systems. The Act (at N.J.S.A. 17:29A-51a(1) and (4)) requires that insurers reduce PIP medical expense benefit premiums by more than almost 25 percent. These rules are intended to support the reductions by providing real reductions in the level of PIP reimbursements. Automobile insureds will experience a reduction in aggregate premiums paid as required by the Act.

The Department will bear the cost of review and approval of these new policy forms, as required by the Act. Additionally, the Department will bear the continuing costs of monitoring the application of the new policy form standards. These costs will be absorbed within the Department's existing appropriations.

Some providers of medical care to persons injured in auto accidents may experience a reduction in revenue. This reduction, in the aggregate, will be comparable to the cost savings of the premium reductions required by the Act.

Federal Standards Statement

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

Jobs Impact

Any assessment of the number of jobs generated or lost upon adoption of these proposed rules would be purely speculative at this time. The Department notes that the Act requires significant reduction in the payments for medical expense benefits through PIP coverage. To the extent that these expenses support jobs among medical providers and their staffs, a reduction in the number of jobs may be inevitable.

The Department notes, however, that medical expenses reimbursed by auto insurance PIP coverage is a relatively small amount of the total medical expenses paid in the State; estimates range downward from less than five percent. Thus, the reduction in total Statewide medical expenses is likely to be less than one percent. Translating this reduction into a number of jobs anticipated to be lost is highly speculative, particularly considering that medical skills for treating persons injured in automobile accidents are equally applicable, and easily transferable, to treatment of persons injured by other causes. Moreover, implementation of standards set forth in these rules may generate additional jobs among those firms that scrutinize medical costs. The Department further notes that businesses unrelated to the provision of PIP medical expense benefits may experience an increase in revenues if insureds choose to spend the premium savings, thus increasing the number of jobs in other sectors.

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 new rules upon agriculture and related industries.

Regulatory Flexibility Analysis

These proposed 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. The Department notes that possible derivative economic impacts on other businesses, some of which may be small businesses as defined at N.J.S.A. 52:14B-17, are referenced in the Economic and Jobs Impacts above.

A few auto insurers transacting business in New Jersey are small businesses. These auto insurers will be required to file changes to their rating system in order to comply with the provisions of the Act, which rating systems include policy forms subject to the standards in these rules. Insurers may be required to obtain the services of lawyers and professional actuarial consultants to prepare the filings, if these services are not available in-house. The costs of the filing represent a one-time capital cost, the amount of which will vary by insurer, and other variables which can not be determined accurately by the Department at this time. Additionally, all insurers including small business insurers will be required to revise management information systems to reflect the policy form and rating changes, which may require one-time capital and on-going maintenance costs. 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 similarly can not be accurately estimated by the Department at this time since they vary greatly based upon each insurer's present data system.

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 new rules follows:

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 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 90 days after the effective date of these rules.

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-3.1 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

4. Recorded, documented and signed 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).

"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.

"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; and

20. 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.

"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.

"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" 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 involve unnecessary testing or treatment.

"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 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) 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) 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 are 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. Thermographs/thermograms;

2. Spinal diagnostic ultrasound;

3. Iridology;

4. Reflexology;

5. Surrogate arm mentoring;

6. Brain mapping;

7. Surface electromyography (surface EMG);

8. Tomography studies for temporomandibular joint disorder (TMJ/D); and

9. 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 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. 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 insured event. Less than a three month testing interval is not normally reimbursable.

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.

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.

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 recommended 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, sonogram/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.

(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 or 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) 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.

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 appropriate 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 before reimbursement of further treatment or tests is authorized.

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 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; 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.

(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.

(d) 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.

(e) No decision point requirements shall apply within 10 days of the insured event.

11:3-4.8 Pre-certification plans

(a) Insurers may file for approval policy forms that provide for a pre-certification of certain medical procedures, treatments, diagnostic tests, or other services, non-medical expenses and durable medical equipment by the insurer or its designated representative.

(b) No pre-certification requirements shall apply within 10 days of the insured event.

(c) Pre-certification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or test.

(d) An insurer that wishes to use a pre-certification 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. 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.

(e) The insurer shall include with its filing, the information about its pre-certification 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) A pre-certification plan may include provisions that require injured persons to obtain durable medical equipment directly from the insurer or its designee.

(g) 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 pre-certification plan.

11:3-4.9 Assignment of benefits

Insurers may file for approval policy forms including reasonable procedures for, or restrictions on, the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.