INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests
Personal Injury Protection Dispute Resolution
Private Passenger Automobile Insurance: Notification by Treating Health Care Providers

Adopted Repeal: N.J.A.C. 11:3-4.10
Adopted Repeal and New Rules: N.J.A.C. 11:3-4.7 and 4.8
Adopted Amendments: N.J.A.C. 11:3-4.1, 4.2, 4.4, 4.9, 5.2, 5.6, 5.11, 25.2 and 25.5

Proposed: July 21, 2003 at 35 N.J.R. 3072(a)

Adopted: May 14, 2004 by Holly C. Bakke, Commissioner, Department of Banking and Insurance

Filed: May 14, 2004 as R.2004 d. 218,with substantive and technical changes not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 39:6A-3.1, 39:6A-4, 39:6A-5 and 39:6A-5.2, and P.L. 2003, c. 89, section 45

Effective Date: June 7, 2004

Operative Date: September 5, 2004 for all amendments, repeals and new rules with the exception of the amendments to N.J.A.C. 11:3-5.6(a), the amendments to 25.2 and 25.5 and 11:3-4.10 repeal, which shall be operative on June 7, 2004.

Expiration Date: January 4, 2006

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received timely written comments from:

One Comment provided jointly by the Insurance Council of New Jersey and the American Insurance Association
The New Jersey Chiropractic Society
Independent Insurance Agents of New Jersey
McCarter & English, Attorneys at Law
Jersey Shore Neurology Associates, P.A.
Association of Trial Lawyers of America - New Jersey
New Jersey Board of Chiropractic Examiners
American Academy of Physical Medicine and Rehabilitation
New Jersey State Board of Physical Therapy Examiners

Atlantic Imaging Group
Bacharach Institute for Rehabilitation
Ronald F. Saltiel
Coalition for Quality Health Care
Norman Brettler
New Jersey Society for Physical Medicine and Rehabilitation
Alexander Pendino, D.O.
New Jersey Hospital Association
Medical Society of New Jersey
New Jersey Association of Electromyography and Electrodiagnosis
Russell I. Abrams, M.D.
American Academy of Neurology
American Physical Therapy Association of New Jersey
Nicholas J. Fano, Esq.
Holly C. Rudolph
E. Gregory M. Cannarozzi
State Farm Insurance Companies
First Trenton Insurance Company
Allstate New Jersey Insurance Company
Alliance of American Insurers
United Services Automobile Association
National Association of Independent Insurers
Liberty Mutual Group
New Jersey Manufacturers Insurance Group
Selective Insurance Company of America

General

COMMENT: One commenter disagreed with the Department's intent to use requirements in the health care marketplace as guidelines for utilization review in the providing of Personal Injury Protection (PIP) benefits. The commenter noted that health plans are bargained benefits between the employer and the employee or its representative. The employer can monitor employees who might abuse the plan and intervene on an individual basis. Further, the commenter argues that health benefit plans are customized to accommodate the demographics of the employee population to minimize "out of network" incidents. Finally, the commenter noted that in health matters, employees are personally incented to accelerate recovery and minimize treatment.

The commenter asserted that PIP is drastically different. There is often no relationship between the patient and the ultimate payor; in many cases the treating physician and an attorney work to maximize the treatment to increase an ultimate bodily injury claim. Another commenter was not sure that the Department's intent to make PIP similar to health insurance was appropriate and that it could have unintended consequences. The commenter promised to monitor this goal over the next few years.

RESPONSE: The Department does not agree with the commenter that the health care industry is not a good model on which to base utilization review for PIP. Since these rules were first proposed in 1998, the Department determined not to "reinvent the wheel" where it was not necessary and to be guided by the provisions of the Health Care Quality Act and the Small Employer Health Benefits (SEH) and Individual Health Coverage (IHC) Programs in fashioning the utilization review requirements for PIP. While there are differences between health insurance and PIP, the Department continues to believe that health insurance is a good model on which to base PIP utilization review.

COMMENT: One commenter requested that the Department require insurers to take an active role in their PIP claims and not abandon them to their vendors. The commenter specifically mentioned Allstate New Jersey as an example of an insurer that only gets involved with its PIP claims when litigation or arbitration is filed.

RESPONSE: The Department does not agree with the commenter's request. The rules give insurers the tools to exercise prospective review of medical treatment for the most common injuries in automobile accidents. It is up to an insurer to decide how to use those tools. Some

carriers may wish to handle PIP claims in house while other carriers may prefer to use the knowledge and experience of a vendor for this.

COMMENT: One commenter requested that the Department require insurers to make available online the certification and licensure of medical directors and physician reviewers. The commenter also requested that physician reviewers maintain unrestricted licenses to practice in New Jersey as well as maintaining sufficient continuing education credits to remain informed of current standards and practices.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, the Department does not believe that the changes requested by the commenter are necessary. The standard for medical necessity does not depend on the qualifications of the physician doing making the determination.

COMMENT: Several commenters, while agreeing that there may be some need to update the provisions of the rule, were concerned that the proposed changes undercut the legislative intent and the mandated rate reductions of AICRA. One commenter also suggested that three years was not enough experience with the PIP protocols to identify necessary changes to the program and that many of the changes in the proposal would jeopardize insurers' ability to fight fraud, abuse and overutilization of medical procedures.

RESPONSE: The Department does not agree with the commenters. As noted in the Summary to the proposal of these amendments, the rules did not conform in many respects to the provisions of Decision Point Review plans as they have developed during implementation of the

rules. In addition, the Department has met extensively with users of the system and is seeking to incorporate into the rules some of the feedback it has received.

N.J.A.C. 11:3-4.1

COMMENT: One commenter believed that the reference to "emergency personal injury protection coverage" in N.J.A.C. 11:3-4.1(a) and (b) should be clarified to state that such benefits are only available under the Special Insurance Policy and not the Basic or Standard policies.

RESPONSE: The Department does not believe that any clarification is needed. "Emergency personal injury protection coverage" is defined in N.J.A.C. 11:3-4.2 to apply only to Special policies.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.1 should be clarified to state that the rule applies to pedestrian and other PIP or medical expense benefits that will be administered by the Property-Casualty Insurance Guaranty Association (PLIGA) taking over for the Unsatisfied Claim and Judgment Fund.

RESPONSE: The Department does not agree with the commenter. N.J.S.A. 39:6-86 governs the administration of pedestrian PIP benefits by PLIGA and, while it refers to a benefit plan approved by the Commissioner, it does not include the same requirements as those contained in N.J.S.A. 39:6A-3.1, 39:6A-4 or 39:6A-4.3.

N.J.A.C. 11:3-4.2

COMMENT: The Department received several comments concerning the definition of "decision point review" in N.J.A.C. 11:3-4.2. One comment opposed the change in the

definition because it did not include language concerning revised filings. In addition, the commenter requested that the Department confirm the validity of the currently approved filings until new plans are filed and approved. Another commenter stated that the definition would prevent an insurer from utilizing the "care path"protocols in determining the appropriateness of treatment in the absence of an approved decision point review plan.

RESPONSE: It is not clear to what the commenter is referring here. A definition would not normally mention filings. If the commenter is asking for confirmation that the changes made by this adoption will not be effective until insurers have received approval on refiled Decision Point Review Plans, that is the Department's normal operating practice and would be the case here.

The Department also does not understand how the definition of "decision point review" would prevent an insurer from using the Care Paths set out in the Appendix of N.J.A.C. 11:3-4 to determine the appropriateness of treatment. The Care Paths are the treatment protocols for the identified injuries that are approved by the Department. If an insurer did not have an approved Decision Point Review plan, it could still evaluate treatment according to the Care Paths. The definition of "decision point review" specifically refers to the procedures in an insurer's decision point review plan.

COMMENT: One commenter requested clarification of the definition of the term "PIP vendor." The commenter questioned whether an entity that simply provided case management software or bill re-pricing services could be considered a PIP vendor.

RESPONSE: The Department does not agree with the commenter that a clarification is necessary. The term "administer," as well as the common practice of insurers who contract out their PIP utilization review to the half dozen or so vendors who perform these services, makes it

clear that simply providing software to be used by an insurer's own employees or the hiring of bill review vendors would not qualify as use of a PIP vendor under the rule.

COMMENT: The Department received several comments concerning the definition of "precertification" in N.J.A.C. 11:3-4.2. Some commenters requested that the original definition, which included the words "prior authorization," remain. The commenter considered the modification to be a weakening of the definition. One commenter believed the definition was ambiguous and asked for clarification as to whether precertification was permitted only when an insurer has an approved decision point review plan and only for treatment not subject to decision point review.

RESPONSE: The Department does not agree with the commenters. The purpose of the amendment was to make the language in the rule consistent with the language in decision point review plans that have been approved by the Department. The Department has never approved a decision point review plan that required pre-authorization of any treatment or testing. Precertification and decision point review differ only in what treatments and tests they cover. All companies must have a decision point review plan for the identified injuries and diagnostic tests. An insurer may include precertification requirements for other procedures and tests in its decision point review plan, but this is optional. The method of requesting precertification and decision point review has always been the same - prior notification that gives the insurer the opportunity to determine medical necessity. The purpose of the amendment is to make the rule conform to this practice. Since a plan requiring pre-authorization of any procedure or testing has never been approved by the Department, changing the definition in the rule does not "weaken" it.

COMMENT: One commenter stated that the integration of pre-certification into the decision point review plan requirements should eliminate some of the current confusion.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter noted that the proposed amendments had finally resolved the conflict regarding the proper applications of "decision point review" and "pre-certification request." The commenter stated that this conflict had resulted in the denial of necessary treatment and testing of injured persons and has led to the filing of arbitrations and court proceedings. The commenter believed that some of the confusion is the result of the use of the term "pre-certification," which has other meanings in health care. The commenter recommended that the term "pre-notification" be used instead of "pre-certification."

RESPONSE: As noted in the Summary of the proposal, most of the amendments to this rule conform it to existing practices. The rules establish what information needs to be in an insurer's decision point review plan. The decision point review plans, approved by the Department, are the documents that should be consulted in any dispute about treatment or testing. The Department has never approved a decision point review plan that made any distinction between the process required to request decision point review and precertification. Every decision point review plan provides for notification to the insurer by the treating medical provider, both for treatment and testing that is subject to decision point review and that is subject to precertification. Therefore, the Department does not understand how this "confusion" could have led to the denial of treatment, arbitrations or court proceedings. With regard to the suggestion that the term "pre-certification" be replaced with "pre-notification," the Department does not agree. First, "pre-certification" is the term used in the statutory descriptions of the

medical expense coverage. Second, the Department believes that to change the term now, when users of the system have become accustomed to its terminology, would be more confusing.

COMMENT: One commenter suggested that the definition of "precertification" in N.J.A.C. 11:3-4.2, "listed specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review…" was incorrect because it was not necessarily the test, procedure or treatment that determined whether decision point review or precertification applies but rather the type of injury being treated -identified or non-identified.

RESPONSE: The Department does not agree with the commenter. Decision point review is defined as, "those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths" and the diagnostic tests listed in N.J.A.C. 11:3-4.5(b) for both identified and non-identified injuries. Therefore, even decision point review is not limited to the identified injuries. Precertification is defined to include anything that is not covered by decision point review. This can be any treatment for a specific diagnosis, a specific type of treatment or test or durable medical equipment.

COMMENT: One commenter believed that the definition of "network" in the proposal was vague and suggested the following definition:

> "'Network' means a health care delivery system through which providers, hospitals and other health care professionals contract to offer medical services to eligible persons under an insurer's benefit plan on a fee-for-services basis at various reimbursement levels."

Another commenter was concerned that the definition of network as an entity "other than an insurer" that contracts with health providers to render health care services" may preclude an insurer that operates a workers' compensation managed care organization (WCMCO) from using the providers and services in its network for automobile insurance. The commenter did not believe that was the Department's intent and recommended deleting the "other than an insurer" from the definition to clarify that a WCMCO network operated by an insurance company is acceptable.

RESPONSE: The Department does not agree with the commenter that the definition of network is vague. The suggested definition refers to eligible persons and a benefit plan, which are terms that are used in health insurance products. In addition, the Department does not wish to restrict reimbursement to fee for service. With regard to the concern that the definition would preclude an insurer from using the providers and facilities of its WCMCO as a network, the Department does not agree with the commenter's concern. A WCMCO is not licensed as an insurer and, in any case, insurer is defined in the rule to mean an automobile insurer.

COMMENT: One commenter suggested that N.J.A.C. 11:3-4.2 should include a definition of what qualifies as a "significant brain and spinal cord injury." The commenter stated that there had been a history of ambiguity about the definition of the term and noted that the Department had defined "significant disfigurement" in N.J.A.C. 11:3-3.2.

RESPONSE: The Department notes that the addition of the definition requested by the commenter would be a substantive change requiring additional notice and public comment.

The Department agrees with the commenter that a definition would be helpful and will consult with the medical representatives on the Personal Injury Protection Technical Advisory Board to develop a definition.

COMMENT: One commenter questioned the Department's interpretation in the Summary of the proposal of "emergency personal injury protection coverage" for the Special Policy to include non-emergency care of significant brain and spinal cord injuries. The commenter believed that this interpretation is contrary to the language of Section 45 of P.L. 2003, c.89.

RESPONSE: At the outset, the Department notes that the Summary of a proposal is not part of the rule. However, the Department believes that its description of emergency personal injury protection coverage is accurate. The definition in Section 45 of P.L. 2003, c.89 is in two parts. The first part describes emergency care and the second part states that, "emergency personal injury protection also includes all medically necessary treatment of significant brain and spinal cord injuries and treatment of significant disfigurement after the patient is discharged from acute care." The inclusion of the words, "all medically necessary treatment" and the reference to treatment "after the patient is discharged from acute care" makes it clear that treatment of the injuries specified in the statute could include non-emergency care. In any case, the definition in the rule refers to the definition in the statute. If that definition is interpreted otherwise by the courts, the definition in the rule will have the same meaning.

N.J.A.C. 11:3-4.4(d)

COMMENT: Several commenters opposed the amendment to N.J.A.C. 11:3-4.4(d) because it is inconsistent with DOBI's Bulletin No. 99-05, which states that "clinically supported findings,"

the term used in the rule, is too vague. One commenter recommended that DOBI incorporate the Bulletin in its entirety, rather than adopt the proposed amendment. Another commenter suggested that the language from the Bulletin, "medical records," be added to the rule.

RESPONSE: The Department does not agree with the commenters that the substitution of "clinically supported findings" for "medical records" represents any change or weakening of the requirements of the rule. First, the Department notes that "clinically supported" is defined in the rule and refers to medical records. Second, and more importantly, the rule is not the place where detailed information about what needs to be submitted with a request for decision point review or precertification should be found. Insurers have the ability in their decision point review plans to set out in detail what information is necessary to support these requests. In addition, the standardized form for making decision point review and precertification requests permitted by N.J.A.C. 11:3-4.7(d) should make it easier for insurers to get the necessary information, as well as making it easier for providers who now have to deal with multiple forms from different insurers or PIP vendors.

COMMENT: One commenter pointed out that N.J.A.C. 11:3-4.7(b)3 provides that penalties may be applied to "tests, treatments, durable medical goods, and non-medical expenses," while N.J.A.C. 11:3-4.4(d) refers to co-payment penalties on diagnostic tests, treatment or durable medical equipment." The commenter requested that N.J.A.C. 11:3-4.4(d) and other references in the rule be conformed to the language in N.J.A.C. 11:3-4.7(b)3 to prevent the interpretation that the penalties cannot be applied to surgery or non-medical expenses.

RESPONSE: The Department agrees with the commenter that the text of the rule should be consistent throughout. The Department does not intend that these differences in text have any

difference in meaning. However, the commenter's suggestion that an even longer list of items be added to every mention of testing or treatment would make the rule unwieldy. The Department notes that most of the references in the rule are to "testing or treatment." There is already a definition of "diagnostic test" in the rule at N.J.A.C. 11:3-4.2. There is also a definition of "treatment plan" in the Glossary of the Care Paths (N.J.A.C. 11:3-4 Appendix, Exhibit 1), which includes surgery. The Department believes that these two categories plus durable medical equipment describe all the possibilities and will amend the rule upon adoption throughout to refer to diagnostic testing, treatment and durable medical equipment.

COMMENT: Another commenter noted that N.J.A.C. 11:3-4.4(d) eliminates the ability of the insurer to use alternative deductible and co-pay options.

RESPONSE: The commenter is correct that this provision was removed from the rule. The Department has not received any filings of decision point review plans with deductible or co-payment options other than those provided for in the rule. The Department believes that uniformity among insurers in deductible and co-payments is important to make the system easier for providers to use.

COMMENT: One commenter believed that the wording in N.J.A.C. 11:3-4.4(d)1 is too obtuse and unclear. The commenter stated that the rule needs to precisely clarify what triggers the penalty and when it ends. As written, the language includes three time frames (time notification required, time made, and time for insurer to respond.) Another commenter stated that the rule needed to be clarified for treatments that occurred between the time the provider gives proper notice and the time that the insurer responds in accordance with its plan. The commenter

believed that the language in the rule supported the interpretation that the penalty may be applied to any treatments that take place between the time proper notice is made and the time the insurer responds in accordance with its plan. The commenter requested that this be made clear in the rule.

RESPONSE: The Department notes that the commenter did not offer any alternative, clearer language for this provision. Language very similar to this is included in all existing, approved decision point review plans. However, in an attempt to clarify this key concept, the Department will amend the rule upon adoption to include the following example. 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 required). The provider does not give the notification in a timely manner but continues to treat the patient. The provider makes the required notification and it is received by the insurer on day 35 (time notification made). The insurer responds on day 38 that the treatment can proceed (time for insurer to respond). Assuming that treatment rendered between day 21 and 38 was medically necessary, it is subject to the 50 percent co-payment.

COMMENT: One commenter objected to the inclusion of "failure to provide clinically supported findings that support the treatment or test requested" as the basis for imposing the penalty co-payment in N.J.A.C. 11:3-4.4(d). The commenter believed that this language would permit an insurer to determine that the requested treatment or test is medically necessary, yet still impose the co-payment penalty because the physician's request did not contain, "clinically

supported findings that support the treatment or test requested." The commenter recommended that the rule be amended upon adoption to condition imposition of the penalty on "failure to provide requested medical records."

RESPONSE: The Department does not understand the commenter's concern. The insurer needs to have sufficient information from the provider to determine whether the treatment or test is warranted by medical necessity. If an insurer can determine medical necessity, then the information supplied meets the requirement of the rule and no co-payment penalty could be imposed. The language suggested by the commenter refers to "failure to submit requested medical records." This does not cover the situation where the provider is making the initial request for decision point review or precertification. Moreover, it does not specifically refer to the information the insurer needs to determine the medical necessity of the requested treatment or testing.

COMMENT: One commenter believes that the use of the term "co-payment" in N.J.A.C. 11:4.4(d) could have the unintended effect of financially penalizing a patient whose physician did not follow the insurer's requirements because "co-payments" are customarily the responsibility of the patient.

RESPONSE: The Department does not agree with the commenter. "Co-payment" and "penalty co-payment" are terms commonly used in health insurance to describe fee amounts that are incurred by patients as a result of their going out of network. Such co-payments are usually the patient's responsibility. However, in the automobile insurance situation, the patient commonly assigns the benefits under the policy to the provider, in which case, the provider becomes subject to the penalty. In all decision point review plans approved for insurers, the Department requires

the inclusion of a provision that prohibits providers who execute assignment of benefits from passing along to the insured co-payment penalties for the provider's failure to follow the requirements in an insurer's Decision Point Review Plan.

COMMENT: One commenter requested that N.J.A.C. 11:3-4.4(d)1 be amended upon adoption to add "based on physician review" to the end of the sentence.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-4.4 concerns deductibles and co-payments. The requirement that the denial of a treatment or test be made by a physician is already in the rule at N.J.A.C. 11:3-4.7(d)4.

N.J.A.C. 11:3-4.4(f)

COMMENT: Many commenters objected to the new subsection (f) under N.J.A.C. 11:3-4.4 that limits penalty co-payments for going out of network to 30 percent. The commenters opposed this new provision on the grounds that a 30 percent threshold would: undermine the cost-efficiency of using an approved network; reduce the incentive for a provider to be in an approved network; and potentially threaten the very existence of the networks, as many non-network providers will merely absorb the reduced 30 percent penalty. The result, according to the commenters, will be the disappearance of networks and an increase in costs of medical treatment. Another commenter stated that the former 50 percent penalty was consistent with the cost containment intent of the Automobile Insurance Cost Reduction Act (AICRA) and that a reduction to 30 percent would make that penalty insufficient. One commenter asked that the Department closely monitor the impact of this proposal and make modifications if consumers react negatively to the change. The commenter believed that use of networks is critical in

reducing fraud, abuse and overutilization and that eliminating insurers' flexibility in determining the penalty level could reduce the saving expected from AICRA.

RESPONSE: The Department does not agree with the commenters and continues to believe that a 30 percent co-payment for going out of network is reasonable and provides a meaningful incentive to use an insurer's network. In response to the allegation that, by adopting a 30 percent maximum co-payment penalty the Department will reduce the savings expected from AICRA, the Department notes that some large insurers do not use networks. As with all the provisions of this rule, the Department will continue to monitor its implementation.

COMMENT: One commenter stated that since the enactment of AICRA, insurers have achieved significant savings in PIP through the use of voluntary networks. The commenter said that networks provided a single point of access for consumers who received timely and quality service. The commenter, a network provider, was not aware of any complaints about this system and believed that changing the existing system would be a disservice to insurers and patients and would only benefit a few special interests. The commenter urged the Department not to adopt the changes to the rule concerning the co-payment penalty.

RESPONSE: The Department does not agree with the commenter. The rules do not prohibit insurers from using networks to provide a single point of access for consumers to receive timely and quality service. The adopted amendments seek to set a reasonable co-payment penalty that will encourage the use of insurer networks without making it impossible for insureds to go out of network if they wish.

N.J.A.C. 11:3-4.4(g)

COMMENT: The Department received several comments about N.J.A.C. 11:3-4.4(g), which explains how the penalty deductible percentage reduction shall be calculated. One commenter recommended that the Department re-word this section with examples because it needs greater clarification. Several commenters believed that the requirement that requiring deductibles and co-payments (N.J.A.C. 11:3-4.4(a) and (b)) to be applied before the application of penalty co-payments (N.J.A.C. 11:3-4.4(d), (e) and (f) would provide undue enrichment of providers at the insured's expense. The commenter provided an example of the problem: the provider bills $400.00 and is subject to the 50 percent co-payment penalty. The insured has a 20 percent co-payment. If the insured makes the co-payment based on the unreduced fee, the provider would receive $80.00 (the co-pay of 20 percent of $400.00) plus $160.00 (1/2 of remaining $320 fee) for a total of $240.00. If, however the penalty co-payment is applied first, the insured would only make a $40.00 co-payment (20 percent of $200.00) and the insurer would pay $90.00 (50 percent of the remaining $180.00) for a total to the provider of $130.00. The commenter requested that the provider not be allowed to pocket the co-payment on the full fee when it is reduced for failure to follow an insurer's decision point review plan. Another commenter questioned if the coordination of co-payments described in the proposal would apply also to the $90.00 daily maximum?

RESPONSE: The Department agrees with the commenters that additional clarification would be helpful. The Department has amended the rule upon adoption to clarify that "what the insurer otherwise would have paid to the insured or the provider" includes application of the medical fee schedule rule, N.J.A.C. 11:3-29. This should eliminate the possibility that any co-payment would be based on what the provider billed in addition to addressing the question about whether

the $90.00 daily maximum is subject to the rule and thus reduce the "unjust enrichment" referred to by one commenter. The Department believes that it continues to be appropriate to apply the deductible and co-payment mandated by statute before the penalty co-payments for failure to follow the requirements of this rule.

N.J.A.C. 11:3-4.7(a)

COMMENT: One commenter pointed out a typo in N.J.A.C. 11:3-4.7(a). The reference should be to N.J.A.C. 11:3-4.4(d), (e) and (f) instead of N.J.A.C. 11:3-4.7(d),(e) and (f).

RESPONSE: The Department will amend the rule upon adoption to correct the error.

N.J.A.C. 11:3-4.7(b)

COMMENT: One commenter requested a clarification of the meaning of the term "administered" in N.J.A.C. 11:3-4.7(b) and suggested that "insured event" in the same section be replaced by "date of accident."

RESPONSE: The Department does not agree with the commenter that a definition of "administered" is necessary. However, since "emergency care" is defined in the rule, the Department will amend the rule upon adoption to delete "treatment administered in" as superfluous text. In using the term, "insured event," the Department is following the language of the PIP statutes, N.J.S.A. 39:6A-3.1 and 39:6A-4.

COMMENT: One commenter requested confirmation that N.J.A.C. 11:3-4.7(b), which states that "no decision point review or precertification requirements shall apply within 10 days of the

insured event or to treatment administered in emergency care" does not require reimbursement of tests and treatments that are not medically necessary.

RESPONSE: Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed substantially from that currently used in the rule and the Department did not intend any change in meaning. Moreover, this provision is also found in N.J.S.A. 39:6A-3.1 and 39:6A-4. Finally, the penalty for failure to request decision point review or precertification where required is application of the 50 percent co-payment for otherwise "medically necessary" treatment.

N.J.A.C. 11:3-4.7(c)

COMMENT: One commenter suggested that N.J.A.C. 11:3-4.7(c)1 be clarified to state that the medical director must be a medical doctor instead of a New Jersey licensed physician.

RESPONSE: The Department does not agree with the commenter that such a change is necessary. "Medical doctor" is not a term that is used in statutes or rules.

COMMENT: One commenter requested clarification as to whether an insurer that did not use a PIP vendor had to have a medical director since the reference to a medical director is contained in the PIP vendor requirements of N.J.A.C. 11:3-4.7(c)1.

RESPONSE: The commenter is correct that the placement of the reference to a medical director in N.J.A.C. 11:3-4.7(c)1 was intended to limit the requirement to PIP vendors.

COMMENT: One commenter stated that it seems inappropriate to require that the medical director ensure compliance with the insurer's entire decision point review plan. The commenter

recommended that the rule be clarified upon adoption to require that the medical director ensure that decision point review and precertification request decisions are made based on medical necessity.

RESPONSE: The Department agrees with the commenter. As noted above in response to a previous comment, the requirement for a medical director has been limited to PIP vendors. It is therefore appropriate to amend the rule upon adoption to clarify that the main duty of the medical director is to ensure that medical necessity decisions rendered by the vendor's medical staff are made in accordance with the standards in the rule.

COMMENT: One commenter requested that this section be amended upon adoption to require that the medical director also be responsible for assuring that physician reviews and medical policies are consistent with current standards of medical care and with actual practices of the majority of physicians in the region where care is being provided.

RESPONSE: The Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, the Department does not believe that such a change is necessary. As discussed above, the Department is amending the rule upon adoption to clarify that the medical director is responsible for making sure that decision point review request and precertification decisions are made based on medical necessity. "Medical necessity" is a defined term that includes compliance with standard professional treatment protocols.

COMMENT: One commenter objected to the requirement that a medical director be a physician licensed in New Jersey. The commenter believed this requirement would unnecessarily limit

some regional or national vendors. The commenter believed that adequate protection was provided by the fact that the director had the necessary expertise and medical training and that the state of licensure was not significant.

RESPONSE: The Department does not agree with the commenter. Provider groups have advised the Department that there is a difference in the requirements for physician licensure among the various states. Further, these provider groups believed that the ability to make complaints about the conduct of the director to the Board of Medical Examiners was important. Finally, an informal survey by the Department indicated that the majority of medical directors were licensed in New Jersey.

11:3-4.7(c)2

COMMENT: Several commenters expressed concern that the provision, which allows insurers to determine which services are subject to precertification, could allow insurers to indiscriminately require precertification of procedures using proprietary information that would not be available for insurer or provider appeals. The commenter recommended that the Department make the determination about what services can and cannot be subject to precertification. Another commenter was concerned that the provision would allow insurers to require pre-certification for all procedures. This commenter recommended that actuarial or scientific proof be required before a procedure is subject to precertification or, in the alternative, have the professional licensing boards in the Division of Law and Public Safety make this determination.

RESPONSE: At the outset, the Department notes that the changes requested by the commenter would constitute substantive changes requiring additional notice and public comment. Although

proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that currently used in the rule. In addition, the Department does not agree with the commenters' suggestion. Insureds and providers cannot appeal the fact that any individual procedure is subject to precertification, so the possible use of proprietary information by an insurer in such an appeal is not an issue. In its review of decision point review plans, the Department scrutinizes what insurers submit and does not permit insurers to require precertification of all procedures. The Department believes further that insurers, rather than the Department or the professional licensing boards, are in the best position to identify those procedures they believe are susceptible to overutilization.

11:3-4.7(c)3

COMMENT: Several commenters recommended that a provision be added to N.J.A.C. 11:3-4.7(c)3 that gives companies lead time to implement the requirement that the insurer's Decision point review plan be put on the company's web site.

RESPONSE: The Department does not agree that a provision giving companies lead-time to implement the web site requirement should be in the text of the rule. There is a 90-day delayed operative date for the adoption that will give insurers and other parties adequate time to implement the changes.

COMMENT: One commenter objected to the requirement that insurers put their decision point review plans on the insurer's web page due to the expense of doing so. The commenter thought it would be preferable for the Department to put the plans on its web site.

RESPONSE: The Department does not agree with the commenter. Using a web site is one of the most cost-effective means of communicating with insureds and providers. Just as insurers are responsible for communicating with their insureds through the US mail, it is appropriate that the insurer be responsible for maintaining information about its decision point review plans on a web site.

COMMENT: One commenter requested clarification that the policyholder is the only individual to whom the materials about networks must be distributed at policy issuance and renewal. Another commenter recommended that the requirement that policy information be distributed to policyholders, injured persons and providers be eliminated. Another commenter noted that the information materials were voluminous and recommended that policyholders be given a one-page summary and be advised that all of the information can be provided upon request and is available on the web.

RESPONSE: The Department agrees with the commenter that the policyholder is the only person to whom materials about networks must be distributed at policy issuance and renewal. The commenters are incorrect in concluding that the text of the rule as proposed would prohibit the one-page summary mentioned by the commenter. N.J.A.C. 11:3-4.7(c) lists the items that must be included with a Decision Point Review filing. It refers to the information materials required by N.J.A.C. 11:3-4.7(d). That subsection lists all the information that must be provided by the insurer but does not specify that all required information needs to be included with every communication to insureds, injured persons and providers. Insurers are encouraged to develop concise, focused communications to be supplied to different recipients and under different circumstances, such as policy issuance and upon notification of claim. The requirement that all

of the insurer's information must be on its web site will assist in producing such focussed communications because the recipients of the communications can be referred to the web site for additional information.

11:3-4.7(c)4

COMMENT: One commenter requested that this provision of the rule, requiring that denial of reimbursement of further treatment or tests be made by a physician or by a dentist in the case of dental treatment, be amended to provide that only chiropractic physicians can make the decision to deny further reimbursement of chiropractic care. Another commenter suggested that denials should be made by a physician "of same or similar specialty as the treating provider." Another commenter stated that many providers, including dentists, are prescribing treatments beyond the traditional expertise of their discipline. This commenter requested that the rule provide that the decisions about the medical necessity of a treatment be made by a specialist in the area of the proposed treatment and not necessarily by the provider who prescribed the treatment.

RESPONSE: At the outset, the Department notes that the changes requested by the commenters would be substantive changes requiring additional notice and public comment. Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that currently used in the rule and the Department does not believe that any changes to this provision are necessary. The Department will monitor this issue and address it in future rulemaking, if necessary.

COMMENT: One commenter recommended that specific time frames be added to the N.J.A.C. 11:3-4.7(c)6 requirement that decision point review plans include a rapid review appeal process.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that currently used in the rule and the Department does not believe that any changes to this provision are necessary. Finally, the Department notes that all decision point review plans approved by the Department include a rapid review process that is designed to get a response in less than two weeks.

COMMENT: One commenter requested that the rule specifically provide that insureds and providers are not required to exhaust the insurer's appeal system before filing for arbitration or in the Superior Court.

RESPONSE: The Department notes that the change requested by the commenters would be a substantive change requiring additional notice and public comment. In addition, the Department does not agree with the commenter that this would be an appropriate change to the rules. The rules provide multiple levels of appeals for providers and insureds with disputes about PIP. It is reasonable that users of the system be encouraged to attempt to resolve disputes directly with the insurer before initiating costly ADR or court proceedings.

COMMENT: Several commenters requested that the language of N.J.A.C. 11:3-4.7(c)4, "denials of reimbursement shall be made by a physician," be changed to require that the physician be licensed in New Jersey and that denials of chiropractic care be made by a chiropractor and denials of podiatric care be made by podiatrist. The commenters contrasted this

provision with that of N.J.A.C. 11:3-5.2, which requires that medical review organization reviewers be of like specialty with the treating physician.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that currently used in the rule and the Department does not believe that any changes to this provision are necessary. The rules provide for different levels of review of medical necessity issues depending on the circumstances. Denials of precertification requests must be reviewed by a physician. Although like specialty is not required, the Department notes that many insurers and their vendors have chiropractors to review requests for chiropractic treatment. However, when a medical review organization does a review as part of an arbitration, it is appropriate to require like specialty review.

COMMENT: One commenter requested that the rule be amended upon adoption to prohibit insurers from denying requests for precertification based on the failure to reach the provider by telephone to request additional information. The commenter stated that providers were often too busy to take calls from insurers and that after the information supporting the treatment request had been supplied to the insurer, oral communication was superfluous.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. The Department agrees that requests for additional information from a provider should be made in writing if the provider cannot be reached by telephone. The Department will monitor complaints on this issue and will do additional rulemaking if necessary.

COMMENT: One commenter requested that N.J.A.C. 11:3-4.7(c)4 be amended upon adoption as follows (additions in boldface, deletions in brackets), "Denials of reimbursement shall be the determination of a physician. **However, denials for failure to attend an independent medical examination ("IME") shall not require the determination of a physician.** [In the case of treatment prescribed by a dentist, the decision shall be by a dentist;]"

RESPONSE: The Department agrees with the commenter in part and has amended N.J.A.C. 11:3-4.7(c)4 upon adoption to delete the reference to reimbursement, which, as was noted in response to another comment, is not correct, and to make it clear that the determination of a physician is required to make denials based on medical necessity. Concerning the commenter's request that the provision of the rule requiring that a dentist deny reimbursement of treatment prescribed by a dentist, the Department notes that although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.6, the language of this provision was not changed from that currently used in the rule. The commenter has not offered any reason for deleting the provision and the Department does not believe that any changes to this provision are necessary.

COMMENT: Several commenters stated the text of N.J.A.C. 11:3-4.7(c)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" was vague and recommend the following additional language: "Failure to respond to requests for treatment and/or tests within three business days shall be deemed consent to the medically[sic] necessity of the requested treatment and/or test."

RESPONSE: The Department does not agree with the commenters. As noted by the commenter, the provision concerning the consequences for failure to respond to a request for treatment or testing is addressed elsewhere in the rule at N.J.A.C. 11:3-4.7(d)4ii. The provision in question is one of a list of requirements for an insurer's decision point review plan. The decision point review plan must contain information about the review period for notifications under the rule. In addition, the amendment upon adoption suggested by the commenter would be a substantive change requiring additional notice and public comment. By failing to respond to a request within three business days, the insurer loses the ability to prospectively deny or modify the provider's treatment request for services previously rendered. This failure has no effect on whether the treatment was actually medically necessary.

COMMENT: One commenter requested clarification as to whether the language of N.J.A.C. 11:3-4.7(c)4 eliminated the ability of an insurer to deny a request for decision point review or precertification because the request lacked the clinically supported findings for the requested treatment.

RESPONSE: N.J.A.C. 11:3-4.7(c)4 states that determinations of requests for decision point review and medical necessity shall be based on medical necessity. If the decision point review or precertification request does not contain the clinically supported findings, the insurer cannot determine if the test is medically necessary and therefore must deny the request.

COMMENT: One commenter noted that it has experienced problems in processing decision point review and precertification requests from providers because sometimes the request is "hidden" among numerous papers. In other cases, the provider sends comments but no clear request and in other cases, according to the commenter, the provider does not provide legible

clinical documentation for the treatment requested. The commenter recommended that N.J.A.C. 11:3-4.7(c)4, 4.7(g) and 25.5(d)4 be amended upon adoption to require that requests for decision point review and precertification be clearly and conspicuously submitted and include complete legible documentation. Another commenter requested that the three business day review period be contingent upon the insurer receiving all of the information necessary to make the decision.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. The Department believes, moreover, that the commenter's concern will be addressed when the Department adopts a requirement that providers use a uniform form to request Decision Point Review and precertification pursuant to N.J.A.C. 11:3-4.7(d). Requiring the use of such a form will benefit insurers by making the request for decision point review or precertification clear and conspicuous.

11:3-4.7(c)6

COMMENT: Several commenters requested a definition of "rapid review" in N.J.A.C. 11:3-4.7(c)6 since, according to the commenter, some carriers have appeal processes that allow up to 90 days for response. The commenter believed that such long response periods conflicted with the Department's intent not to interrupt a course of treatment.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that currently used in the rule and the Department does not believe that any changes to this provision are necessary. Finally, the Department notes that

all decision point review plans approved by the Department include a rapid review process that is designed to get a response in less than two weeks. Some insurers also have a non-expedited appeal process that can take longer.

COMMENT: One commenter suggested that the rule stipulate that a medical necessity appeal in the internal appeal process be done by a physician who is board certified in a similar specialty as the treating physician and who is not the reviewer who issued the original denial.

RESPONSE: The Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. The Department does not believe that it is necessary to require same specialty review for the internal appeal process. The internal review process give the provider an opportunity to submit additional information in support of his or her treatment request and have it reviewed again. Same specialty review is provided for in independent medical examinations and as part of reviews by Medical Review Organizations in the alternate dispute resolution process.

N.J.A.C. 11:3-4.7(d)

COMMENT: One commenter supported the requirement in N.J.A.C. 11:3-4.7(d)1 that PIP vendors be available during normal business hours to respond to requests for decision point review and precertification. The commenter suggested an addition to this provision regulating how insurers notify providers about the requirements of their decision point review plans. The commenter requested that insurers be obliged to send providers a copy of its decision point review plan within 10 days of the notification of treatment and that failure to do so would stop the insurer from imposing any co-payment penalty on the provider.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, the Department does not agree with the commenter. N.J.A.C. 11:3-4.7(d)1 is part of a list of items that must be in an insurer's decision point review plan. N.J.A.C. 11:3-4.7(c)3 requires that insurers describe in their decision point review plan filing how they plan to distribute the plan to policyholders, injured persons and treating providers, both at initiation of the policy and upon renewal, and upon filing of a claim. The Department reviews these distribution methods as part of its review of the insurer's Plan. The Department also notes that, upon adoption of this rule, insurers will be obligated to put their Decision Point Review plans on a web site, which should make access by providers easier.

COMMENT: Several commenters opposed proposed N.J.A.C. 11:3-4.7(d), which authorizes the Commissioner to issue an order requiring the use of uniform forms, layouts and language of information material because it fails to provide the industry with an opportunity to comment on these forms. The opportunity for public comment is important because the regulation seeks to develop uniformity, although each insurer will have different information to provide. Therefore, the commenter's recommended that this section be subject to the promulgation of regulations rather than the issuance of an order. A commenter also recommended that companies be allowed to use their existing forms prior to the adoption of a regulation identifying the uniform forms, layouts and language of informational material.

RESPONSE: The Department does not agree with the commenters. The Department has already developed a process through its Personal Injury Protection Technical Advisory Committee (PIPTAC) for the development of uniform forms. This process seeks input from both

providers and insurers. If the forms were included in the rule, any modification of them would involve a protracted process. As is its normal practice, the Department's implementation of this provision will be timed to allow for insurers and providers to make the necessary adjustments to their systems and existing forms.

N.J.A.C. 11:3-4.7(d)4

COMMENT: Several commenters suggested that N.J.A.C. 11:3-4.7(d)4i be amended to refer to "business" days rather than "working" days.

RESPONSE: The Department agrees with the commenter and has amended the rule upon adoption to change "working" days to "business" days.

COMMENT: Several commenters recommended a change to N.J.A.C. 11:3-4.7(d)4ii. The commenters were concerned that the language as written incorrectly correlates the decision point review/precertification request decision with payment of the bill. Decision point review and precertification decisions are based solely on medical necessity, and these medical necessity decisions do not always correlate with payment of the bill (that is, causality issues). Currently, this distinction is not clearly understood by the medical community and the language as proposed further blurs this important difference. The commenter recommended that the language be changed to read: "…treatment or testing may proceed until the insurer notifies the provider that the request is not authorized."

RESPONSE: Upon review, the Department has determined to amend the rule upon adoption to delete N.J.A.C. 11:3-4.7(d)4ii. It is a duplication of the requirement at N.J.A.C. 11:3-4.4(d)1

and it is not necessary to repeat it here since an explanation of the provisions of N.J.A.C. 11:3-4.4(d) is required to be included in the decision point review plan by N.J.A.C. 11:3-4.7(d)6.

COMMENT: One commenter believed that the language of N.J.A.C. 11:3-4.7(d)4ii, "If the insurer fails to respond to a request for decision point review/precertification within the timeframes called for in its plan, the treatment or testing may proceed until the insurer notifies the provider that reimbursement for the treatment or testing is not authorized," meant that the insurer could fail to respond to a request for treatment or testing within the timeframes in the insurer's plan and then retrospectively deny reimbursement. The commenter questioned why any provider would submit treatment requests if they could be subject to retrospective denial.

RESPONSE: As noted above in response to the previous Comment, the Department has determined to delete N.J.A.C. 11:3-4.7(d)4ii upon adoption as duplicative. The Department notes that the commenter's concern about retrospective denial is addressed at N.J.A.C. 11:3-4.7(g).

COMMENT: One commenter objected to the addition of language to a provision in Bulletin 99-05 which was proposed to be codified as N.J.A.C. 11:3-4.7(d)4ii. The language is, "the treatment or testing may proceed until the insurer notifies the provider that reimbursement for the treatment or testing is not authorized." The commenter believed this language would have a significant negative impact on persons seeking treatment for injuries sustained in auto accidents in New Jersey. The commenter believes that the three business day window of opportunity for review of proposed treatment is more than ample and noted that precertification does not mandate payment and insurers still have the ability to determine the medical necessity of the test

or treatment prior to any payment to the provider. The commenter provided some examples where this provision of the rule would cause a negative impact on patients. These included a request for precertification of a series of three trigger point and/or facet injections during a one-month period. After not responding to the initial request, the insurer denies the request after the first injection and the rest of the series cannot be performed. Another example provided was where a request for decision point review of a diagnostic test is made. The insurer does not respond during the three-day review period. The patient is scheduled for an appointment in two weeks and on the day before the test is to be administered, the insurer responds to the request by denying it. The provider cannot perform the test and cannot reschedule the appointment time.

RESPONSE: As noted above, the Department is amending the rule upon adoption to delete N.J.A.C. 11:3-4.7(d)4ii as duplicative. However, since the same requirement is found in the rule at N.J.A.C. 11:3-4.4(d)1, the Department will address the commenter's concerns. Amending the rule upon adoption to require that insurers deny decision point review and precertification requests within the three-day period would be a substantive change requiring additional notice and public comment. The conduct by insurers described by the commenter where late denial disrupts patient care would seem, absent other factors, such as requesting additional information, to be an abuse of the goals of the decision point review plan system. The Department will review this issue further with the PIPTAC and may address it in future rulemaking.

COMMENT: One commenter requested that when an insurer denies a treatment plan, the name and contact information of the physician reviewer be provided as well as the "clinical rationale" for the denial. The commenter requested that if the denial is for "insufficient documentation,"

the denial should include a list of the documentation reviewed, as case managers frequently fail to forward all submitted documentation to the reviewer.

RESPONSE: As noted above, the Department is amending the rule upon adoption to delete N.J.A.C. 11:3-4.7(d)4ii as duplicative. However, since the same requirement is found in the rule at N.J.A.C. 11:3-4.4(d)1, the Department will address the commenter's concern. The changes requested by the commenter would be a substantive change requiring additional notice and public comment. The Department agrees that it is in the interest of all parties that the provider whose decision point review or precertification request is denied should receive sufficient information on the reasons for the denial, so as to be able to pursue an internal appeal or provide additional information. The Department will monitor complaints on this issue and may do additional rulemaking if warranted.

COMMENT: One commenter requested that N.J.A.C. 11:3-4.7(d)4ii provide for the ability of an insurer to notify the insured or claimant that reimbursement for the treatment or testing is not authorized, rather than just the provider. The commenter stated that this would be necessary in cases where the treatment or testing will not actually be performed by the provider.

RESPONSE: As noted above, the Department is amending the rule upon adoption to delete N.J.A.C. 11:3-4.7(d)4ii as duplicative. However, since the same requirement is found in the rule at N.J.A.C. 11:3-4.4(d)1, the Department will address the commenter's concern. The Department does not believe that such a requirement should be incorporated into the rule as circumstances of requested treatment and testing can vary greatly.

COMMENT: One commenter requested clarification on how the language in N.J.A.C. 11:3-4.7(d)4i, which states that "telephonic responses will be followed up with a written authorization, denial or request for more information within three working days" (emphasis added). The commenter wanted to know what was the time frame for the insurer to respond once the additional information was provided before the provider could assume that the insurer was not going to respond and continue with treatment.

RESPONSE: The Department believes that three business days is established in the rule as the time period for an insurer to review an initial request for decision point review or a subsequent submission of information and that treatment can continue after a failure to respond within that time.

COMMENT: One commenter requested that the Department prohibit an insurer from penalizing a provider for an office visit within an authorized treatment period when higher levels of specific therapy have been approved but found to be inappropriate or unnecessary at the time of the visit.

RESPONSE: The Department is not aware of this specific problem with this aspect of the approval of treatment plans. The Department will seek additional information on this issue and, if necessary, will do additional rulemaking.

N.J.A.C. 11:3-4.7(e)

COMMENT: One commenter supported the provisions of N.J.A.C. 11:3-4.7(e) that eliminate the penalty co-payments on providers for failure of an insured to attend an independent medical examination. The commenter suggested that the rule be amended upon adoption to state that the

insured is responsible for paying the provider for any uncovered services that are attributable to the patient's failure to cooperate with the insurer's request.

RESPONSE: The Department does not agree with the commenter that the rule needs to be amended upon adoption to address the commenter's concern. Any treatment that is not covered by the policy is the responsibility of the patient. The only exception is balance billing the injured person for charges in excess of what the insurer pays to the provider. One purpose of the proposed new rule was to require that providers be informed when insureds are required to attend independent medical examinations and when further reimbursement for treatment is denied because of a failure to cooperate. The provider is then aware that continued treatment may not be reimbursable by the insurer and therefore is the patient's responsibility.

N.J.A.C. 11:3-4.7(e)1

COMMENT: One commenter requested clarification about when the notice required by N.J.A.C. 11:3-4.7(e)1 shall be given. The commenter also requested that the Department confirm that a description of the consequences for failure to comply with the physical examination is sufficient notice. Another commenter requested confirmation that including the notice in the information materials supplied at the initiation of the claim is sufficient to meet this requirement.

RESPONSE: The Department does not understand the commenter's request for clarification. When an insurer wishes to have a physical examination of the injured party, it notifies him or her of that fact. Generally speaking, a description of the consequences for failure to comply with the requested physical examination would be sufficient notice of those consequences. The content and format of the specific notice used by the insurer is subject to the Department's review of the

insurer's decision point review plan. The Department does not believe that including the notice in the informational materials supplied at initiation of a claim would be sufficient to meet the requirement. The notice sent to the insured requesting or scheduling the examination should include a mention of the consequences for failure to attend.

COMMENT: Several commenters noted that, in several places in N.J.A.C. 11:3-4.7(e), the rule requires that the insurer give notifications to insureds. These include N.J.A.C. 11:3-7.4(e)1 and 6. The commenter requested confirmation that the insurer or its designated vendor could give these notices and suggested amendments to the rule to include the vendor.

RESPONSE: The Department has never, in approving decision point review plans, made any distinction between notification by the vendor or insurer. However, to try and eliminate any confusion, the Department is amending the rule upon adoption to add a sentence to the definition of insurer, which states that for purposes of notifying insureds and providers as part of administering its decision point review plan, "insurer" includes a PIP vendor.

COMMENT: One commenter recommended adding a new section to N.J.A.C. 11:3-4.7(e)2 as follows: "Insurers may also include in their decision point review plan 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 and included in the decision point review/precertification request that necessitated the physical examination, in the event of an unexcused failure by the patient to attend the requested exam. This additional co-payment is the responsibility of the patient and not the provider."

RESPONSE: The Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. The Department does not believe that it would be appropriate to retroactively penalize the patient for treatment made by a provider that was later determined not to be medically necessary by a physical examination.

COMMENT: One commenter opposed the elimination of the ability of insurers to impose a penalty co-payment when the insured fails to attend the physical examination. The commenter believes that this requirement sends a wrong message to claimants and would place the penalty for failure to attend the examination on the insurer. The commenter stated further that insurers need to be able to recoup the costs associated with a claimant's failure to attend a scheduled physical examination. The commenter believed that providers have greater control over conducting the examination than insurers.

RESPONSE: The Department does not agree with the commenter. The Department believes that the proposal takes a balanced approach on dealing with failure to attend physical examinations. If, based upon continued monitoring, it is determined that this approach is not working, the Department may do additional rulemaking.

N.J.A.C. 11:3-4.7(e)2

COMMENT: One commenter requested clarification about what the term "scheduled" means in this section. The commenter stated that the Department originally stated that this section meant that the appointment had to be conducted within seven days but had later changed this to require only that the appointment for the examination must be made within seven days, with no restriction on the length of time before the actual examination. The commenter believed that the

second interpretation posed an unfair burden on providers who face repeated denial of care "pending examination."

RESPONSE: The Department does not agree with the commenter that the section requires clarification. The original rule stated that , "The physical examination must be scheduled…." The proposal states that, "The **appointment** for the physical examination must be scheduled…." (emphasis added). Therefore, it is clear that it is the appointment that must be scheduled within the seven days. The issue that the commenter raises about delays in treatment because of the failure of insurers to conduct examinations in a timely fashion is beyond the scope of this proposal. The Department and its Personal Injury Protection Technical Advisory Board will look into the appointment scheduling issue to determine if additional changes to the rule need to be made.

N.J.A.C. 11:3-4.7(e)3

COMMENT: Several commenters requested that the language of the rule that states that, "the medical examination shall be conducted by a provider in the same discipline as the treating provider" be amended to require that the examining physician be in the same "specialty" as the treating provider. Another commenter suggested that the rule state that, "the examination shall be conducted by a **practicing** provider in the same **specialty** as the treating provider." (emphasis added). Another commenter noted that providers in one discipline are increasingly prescribing treatment beyond the traditional expertise of that discipline. As an example, the commenter stated that dentists or family practitioners prescribe pain management treatment. The commenter suggested that it is more appropriate and beneficial for the patient to have the examining

physician be in an appropriate area of expertise if the proposed treatment is outside the traditional expertise of the prescribing physician.

RESPONSE: At the outset, the Department notes that the change requested by the commenters would be a substantive change requiring additional notice and public comment. Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that currently used in the rule and the Department does not believe that any changes to this provision are necessary.

N.J.A.C. 11:3-4.7(e)5

COMMENT: The Department received many comments on N.J.A.C. 11:3-4.7(e)5, which requires the injured person to bring pertinent medical records to the examination. One commenter requested that the rule discuss the implications if an injured person fails to provide the medical records and other pertinent information, despite the request. The commenter also proposed that the Department add a penalty provision for failure to provide the information requested. Another commenter suggested that the three-day period after the physical examination for the insurer to notify the injured person shouldn't start until the examining physician is provided with the medical records. Another commenter, noting that the examining physician must base his or her determination on the information provided, suggested that the consequences for failure to provide the necessary information be included in the rule in addition to a prohibition on the filing for alternate dispute resolution until the necessary information is supplied. Another commenter noted that the language in the rule that requires the injured person to provide medical records to the examining physician could be interpreted to relieve the treating provider from any obligation to provide the records. The commenter requested that the rule be

amended upon adoption to require that the treating provider supply the medical records to the insured. Several commenters also questioned the requirement in this provision that the "injured person" provide medical records for the examination. The commenter believes that the insurer already has medical records due to decision point review and precertification requests. Alternatively, the commenter believes that the treating medical provider is a more appropriate person to provide medical records than the injured person.

RESPONSE: The Department notes that the only substantive change proposed to the text of the existing rule was to delete the treating provider as a party from whom the insurer could request the medical records. The change was made in response to complaints by providers that since it was the insured's responsibility to attend the IME, the insured should be responsible for providing treatment records at the same time. It is clear from the comments that this issue needs further review by the Department, which may include additional rulemaking. All the suggestions of the commenters for amendments upon adoption would be substantive changes requiring additional public notice and comment.

COMMENT: One commenter believed that the use of "provider" in N.J.A.C. 11:3-4.7(e), in the phrase: "the provider conducting the medical examination," is incorrect, as the physician conducting the examination is not providing medical care.

RESPONSE: The Department does not agree with the commenter. A "provider" is defined in the rule as, "persons licensed or certified to perform health care treatment or services compensable as medical expenses." This definition would include activities such as providing physical examinations.

COMMENT: One commenter suggested that N.J.A.C. 11:3-4.7(e)5 be amended upon adoption to provide that the disclosure of any and all private health information shall be subject to federal Health Insurance Portability and Accountability Act (HIPAA) requirements.

RESPONSE: The Department does not agree with the commenter that the rule needs to be amended upon adoption to address the commenter's suggestion. The requirements of Federal law apply whether or not specific mention of them is made in the rule. All members of the health care industry need to determine if, and to what extent, they need to comply with HIPAA.

N.J.A.C. 11:3-4.7(e)6

COMMENT: One commenter recommended that the rule require that the insurer notify the treating medical provider of his or her patient's physical examination. The commenter stated that this would enable the provider to make sure that the patient attends the examination.

RESPONSE: The Department does not understand the commenter's recommendation. N.J.S.A. 11:3-4.7(e)1 requires the insurer to notify the treating provider of a scheduled physical examination if a consequence of a failure to appear at the examination is the cessation of reimbursement for further treatment.

COMMENT: One commenter supported the setting by the rule of a maximum time frame for review of decision point review and precertification requests. The commenter stated that it would prefer a two-day review but was satisfied with the three-day requirement in the rule.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters recommended that N.J.A.C. 11:3-4.7(e)6 be amended upon adoption to require that the examining physician prepare a written report and that a copy of the report must be provided to the injured person and the injured person's treating physician. One commenter supported this recommendation by stating that the examining physician's report could be helpful to the treating physician in caring for the injured person because they refer to alternate diagnoses and treatment options. The commenter believed these reports should be treated as "second opinions." In addition, the commenter alleged that insurers sometimes deny further treatment when the report of the examining physician recommends continued treatment or testing. Another commenter noted that the provider needs to see the examining physician's report to be able to appeal the decision.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that in the current rule. The Department will consider whether the changes recommended by the commenter should be implemented with the Personal Injury Protection Technical Advisory Board.

N.J.A.C. 11:3-4.7(e)7

COMMENT: Many commenters expressed support for the amendments that are designed to prevent a provider from being penalized for the failure of the patient to attend a medical examination.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter recommended that the rules should make it clear that if the patient fails to cooperate with the physical examination process, the patient will be responsible for paying for any treatment not paid for by the insurer. The commenter does not believe that the provider should be penalized for the patient's failure to attend the examination.

RESPONSE: The Department agrees that the provider should not be penalized for the failure of the patient to attend the physical examination. The Department's rule provides for this by ensuring that the provider has notice that an examination has been scheduled and that, if the patients fails to attend, the insurer will no longer reimburse for treatment. It is then up to the provider whether he or she wishes to continue to treat.

COMMENT: One commenter believed that the proposed amendment that permits insurers to deny reimbursement of treatment for multiple unexcused failures to attend a scheduled physical examination was more harsh than the current provision, which imposed a 50 percent co-payment penalty in such cases. Another commenter suggested that, in addition to permitting an insurer to deny reimbursement for failure to attend the examination, the insurer should be permitted to impose a 50 percent co-payment on the insured for treatment incurred after the failure to attend the scheduled examination.

RESPONSE: The Department does not agree with the commenter. While the rule does provide for denial of reimbursement for failure to attend an examination, it also requires that the treating provider be notified so that he or she can decide whether to continue with treatment. Concerning the suggestion to have a 50 percent co-payment penalty on the insured for failure to attend an examination, the Department notes that the change requested by the commenter would be a

substantive change requiring additional notice and public comment. In addition, since most patients assign benefits, it would be complicated to administer.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7(e)7 and 4.8(d)8 were inconsistent with N.J.S.A. 39:6A-13(d).

RESPONSE: The Department does not agree with the commenter. The physical examinations that are referenced in N.J.A.C. 11:3-4 are different than the independent medical reviews governed by N.J.S.A. 39:6A-13(d).

COMMENT: One commenter requested that the Department clarify the use of the term "unexcused" in N.J.A.C. 11:3-4.7(e)7. The commenter stated that some carriers consider a 10 to 15 minute arrival delay to be "unexcused." The commenter believed that it was unfair to penalize the insured for being late to examinations that are conducted in places unfamiliar to the insured. The commenter also requested that providers be notified if an absence is excused or unexcused.

RESPONSE: The Department is providing specific authorization to insurers to penalize the insured for an unexcused failure to attend a physical examination for the first time in this rulemaking. The Department will give insurers some flexibility to define what a "failure to attend" in their Decision Point Review plans. If necessary, the Department will do additional rulemaking to address this issue.

COMMENT: Several commenters objected to the provision in N.J.A.C. 11:3-4.7(e)7 that requires repeated unexcused failures to attend a physical examination before further

reimbursement for treatment can be denied. Several commenters proposed that insurers be authorized to implement these procedures upon the first unexcused failure to attend if the notice of the first examination contained a clear explanation of the consequences for failure to attend. Another commenter suggested the following language (additions in boldface, deletions in brackets), "Insurers may include in their decision point review plan a procedure for the denial of reimbursement for treatment or testing after [an repeated unexcused] **a** failure to attend a [schedule] physical examination **that has been scheduled on at least two occasions**."

RESPONSE: The Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. The Department believes that the language as proposed recognizes the needs of the insurer and the patient. It provides an insurer with the ability to deny further reimbursement when an insured will not cooperate with a request for a physical examination while not making unreasonable requirements on the insured. The Department does not agree with the language suggested by the commenter. The commenter's suggested language would eliminate the flexibility given to insurers to determine when they will deny further reimbursement.

N.J.A.C. 11:3-4.7(f)

COMMENT: One commenter requested that the last sentence of this provision be amended upon adoption to read (additions in boldface, deletions in brackets), "In addition, the insurer [may] **must** provide that reimbursement for treatment or tests consistent with the agreed plan will be made without review or audit." The commenter expressed the opinion that AICRA had shifted the review period to prior to treatment and that retroactive review is now redundant and inappropriately delays payments.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. Although proposed as a new rule because of the reorganization of N.J.A.C. 11:3-4.7 and 4.8, the language of this provision was not changed from that currently used in the rule and the Department does not believe that any changes to this provision are necessary.

N.J.A.C. 11:3-4.7(g)

COMMENT: One commenter recommended that the rule should make it clear that if the patient presents fraudulent information that is unknown to the insurer, the patient should be held financially responsible for any unpaid services.

RESPONSE: The Department does not agree with the commenter that it is necessary or appropriate to put such a provision in a rule that provides minimum standards for decision point review plans to be submitted by insurers. There are other rules that govern fraudulent activity.

COMMENT: Several commenters noted that, while decision point review and precertification address medical necessity, the no-fault statute has other requirements that can cause a retroactive denial of reimbursement. The commenters noted that some providers do not understand this issue and recommended that language be added to N.J.A.C. 11:3-4.7(g) specifying the other grounds upon which reimbursement may be denied. One commenter suggested that "material misrepresentation" be added as an acceptable criterion, in addition to fraud, for a retrospective denial.

RESPONSE: The Department agrees with the commenters that there are reasons other than medical necessity for the retrospective denial of payment for a claim. The statute requires that

the injuries being treated were caused by the motor vehicle accident, that there is coverage in force and the person receiving treatment is eligible under the policy. Upon review, the Department has decided to clarify this issue not by adding more grounds for retrospective denial but by amending N.J.A.C. 11:3-4.7(g) upon adoption to limit it to retrospective denials based on medical necessity. Insurers can still avail themselves of the bases for denial provided by other statutes and rules. Concerning the addition of "material misrepresentation" to the grounds for retrospective denial, the Department believes that "material misrepresentation" is normally considered to be fraud. However, in the interests of clarity, the Department will amend the rule upon adoption to refer to "fraud and misrepresentation" as defined in N.J.A.C. 11:16-6.2.

N.J.A.C. 11:3-4.7(h)

COMMENT: Several commenters requested an addition to the rule providing that an insurer may not deny or reduce payment to the provider unless the provider had materially misrepresented or failed to perform the services or made a purposeful and knowing submission of fraudulent information.

RESPONSE: The Department notes first that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, the Department does not agree with the commenters. The statutory standard for reimbursement of medical expenses is medical necessity, not the absence of fraud. Therefore, insurers must have the ability to retrospectively deny reimbursement on the basis medical necessity. However, such denials should be extremely rare when the provider has submitted a decision point or precertification request since insurers have the ability for prospective review.

COMMENT: One commenter suggested that a provision be added to this subsection that assesses a 20 percent penalty on an insurer that fails to pay for a pre-certified service within the time frames required by N.J.S.A. 39:6A-5.

RESPONSE: N.J.S.A. 39:6A-5 itself sets forth penalties for late payments by insurers.

COMMENT: One commenter requested that a subsection (h) be added to N.J.A.C. 11:3-4.7 that would permit an insurer to deny reimbursement to a provider who is found not to be licensed at all, or is licensed but not authorized to provide the services in the field for which reimbursement is being sought.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, this rule concerns the contents of decision point review plans and not eligibility of providers to receive PIP payments.

N.J.A.C. 11:3-4.8

COMMENT: Several commenters questioned the statutory authority of the Department to regulate the use of networks by auto insurers. The commenters noted that the Department based the requirements for auto insurer networks on those developed for selective contracting arrangements and pointed out that the selective contracting arrangement regulations were promulgated after passage of the Health Care Quality Act and observed that the Legislature has not enacted any corresponding law with respect to the regulation of networks for PIP.

RESPONSE: The Department does not agree with the commenters. The two PIP statutes, N.J.S.A. 39:6A-3.1 and 39:6A-4, give the Commissioner the ability to establish the benefit plan

provided by the policy. In addition, N.J.S.A. 39:6A-4 states that the policy may provide benefits in excess of the basic benefits that are subject to a reasonable co-payment. The Department believes that these statutes provide sufficient authority for the Commissioner to regulate the use of networks in the context of automobile insurance.

COMMENT: Several commenters stated that, while there is some justification for seeking information about networks used by auto insurers, the process in the proposed rule was overkill. As examples, the commenters questioned why the Department needed information on the financial arrangements between the network and its providers. With respect to this requirement, the commenter believed that a simple designation of the network payment scheme as fee for service, capitation or fee for service plus a bonus would be sufficient. In addition, the commenter believed that the information required from networks concerning their financial stability was unnecessary, since the insurer is responsible for claim payments and there would be no impact on insureds or providers if a network became bankrupt. In addition, the commenter believed the following requirements for PIP networks were excessive: the requirements for malpractice coverage and the information required on complaint and grievance procedures. The commenter recommended that it would be more productive to have a procedure whereby an insurer could certify its network, subject to the Department's investigation and oversight in the event problems arise.

RESPONSE: The Department agrees in part with the commenters. Upon review of the comments received, the Department has determined that it is not necessary to implement a new certification process for auto insurer voluntary networks. The entities that provide the services permitted for automobile insurance voluntary networks are already authorized as HMOs by the

Department of Health and Senior Services (see N.J.S.A. 26:2J-1 et seq. and N.J.A.C. 8:38A-4.10), or certified, approved, or registered by the Department or by the Department of Health and Senior Services for selective contracting arrangements (see N.J.A.C. 11:4-37.4(c)), workers compensation managed care organizations (see N.J.A.C. 11:6-2.4(c) and 2.5(b)) or organized delivery systems (see N.J.A.C. 11:22-4.5(b) and (e) and 8:38B). The Department notes that the Department of Health and Senior Services' rules for the registration of non-risk bearing Organized Delivery Systems were adopted on February 17, 2004. These various rules establish approval/credentialing procedures that are substantially similar in all significant respects to those in the proposal. Furthermore, as proposed, N.J.A.C. 11:3-4.8(d)13 provided that if a network was currently certified for another insurer or approved as part of a selective contracting arrangement pursuant to N.J.A.C. 11:4-37, in lieu of providing the information referenced in paragraphs 5 through 12 of that subsection it could substitute documentation evidencing such certification or approval. The Department has concluded that requiring a separate certification process for auto insurance networks would be duplicative. The Department's concern that voluntary networks used in auto insurance provide quality services is met by requiring that, in order for it to be used for auto insurance, the network must be approved or credentialed for one of the purposes mentioned above. Accordingly, upon adoption the Department has amended N.J.A.C. 11:3-4.8(d) to so indicate, and will only adopt subparagraph i of paragraph 2 and will not adopt paragraphs 4 through 13 of subsection (d) as proposed. As a result of the non-adoption of those paragraphs in subsection (d), the Department has also declined to adopt subsections (e), (f) and (g) of N.J.A.C. 11:3-4.8 as proposed, all of which addressed the proposed separate certification process for voluntary networks. These changes upon adoption will alleviate the regulatory burden the rules as proposed would have imposed on the entities that provide services permitted

for auto insurance voluntary networks. In addition, they will maintain essentially the same standards for qualification initially proposed for voluntary networks, as the criteria enumerated in the paragraphs in subsection (d) that were proposed but are not being adopted are consistent with and reflective of the criteria for approval or credentialing of networks set forth in the rules referenced above.

COMMENT: One commenter questioned the Department's statutory authority to regulate the use of networks by auto insurers. In particular, the commenter believed that the requirements in N.J.A.C. 11:3-4.8(d) concerning the quality assurance programs and complaint and grievance systems do not involve the statutory duties assigned to the Department and would be more appropriate for the Department of Health and Senior Services. The commenter recommended that N.J.A.C. 11:3-4.8(d) be eliminated.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

COMMENT: Several commenters objected to the requirement that insurers certify to facts of which they don't have first-hand knowledge. The proposal puts insurers in the position of guaranteeing the representations of networks, which are presumably separate legal entities. Another commenter stated that insurers contract with PIP vendors that specialize in provider solicitation for networks, network solicitations, and credentialing. This commenter recommended that the rule be amended upon adoption to permit PIP vendors to make the required certifications if the voluntary network is not offered directly by the insurer.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 that required a separate network certification process.

COMMENT: One commenter requested a clarification that specifically prohibits the use of voluntary networks for treatments, modalities, and examinations encompassed by CPT codes 97001 through 99291. The commenter believed such an express prohibition would resolve disputes on this issue that had gone to Alternate Dispute Resolution and the Superior Court.

RESPONSE: The Department does not agree with the commenter. The CPT codes referenced by the commenter are for physical therapy and chiropractic and osteopathic manipulation treatments. The benefits that are covered by CPT codes for which voluntary networks are permitted are Magnetic Resonance Imagery, Computer Assisted Tomography and the electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3. The CPT codes for these tests are not located in codes 97001 through 99291. Durable medical equipment and prescription drugs are not designated by CPT.

COMMENT: One commenter suggested that the rule be amended upon adoption to state that if an insurer failed to supply the provider with its list of clients pursuant to N.J.A.C. 11:3-4.8(d) or to have its network properly certified, the insurer should not be able to impose the 30 percent co-payment penalty for going out of network.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 that required a separate network certification process. The Department does not agree with the commenter's suggestion that it is necessary to

specifically state that an insurer cannot use the 30 percent penalty for going out of network if its network did not meet the requirements of this rule. The out-of-network penalty is limited and can only be used with networks that meet the requirements of this rule.

COMMENT: One commenter stated that since the medical coverage in an auto insurance policy is an indemnity benefit, the establishment of networks is not in the best interests of the patients. The commenter believed that patients should be able to access the entire array of diagnostic services available through PIP without being limited to a list of providers selected on the basis of cost.

RESPONSE: The Department does not agree with the commenter. The use of networks does not limit a patient to any providers. It simply provides an opportunity for insurers to give patients quality services at negotiated rates that maximize the patient's PIP benefits.

COMMENT: Several commenters expressed the concern that permitting testing networks was one step away from permitting networks of treating health care providers for outpatient care such as physical therapy. One commenter believed that this would simply reduce short-term costs since, if quality of outcome is not also measured, the system would bear higher costs in the future as a result of poor service in the network. Another commenter was concerned that all incentives to seek healthcare are monetarily based instead of focusing on quality of care.

RESPONSE: The Department understands the commenter's concerns. There are no plans to expand the list of services for which networks may be used. The Department also believes that requiring networks used in auto insurance to be those already approved for other health and

workers' compensation insurance is the most effective and least burdensome way in which to provide quality care.

COMMENT: One commenter requested that the rule be amended upon adoption to permit what the commenter referred to as voluntary "passive networks." A passive network is one where the insurer offers a network for all services but there is no penalty to the insured for not using the network. The commenter went on to say that there is no need for the Department to regulate such networks.

RESPONSE: The Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, the Department does not agree that it is necessary to amend the rule upon adoption to permit what it refers to as "voluntary passive networks." The rule establishes parameters for those aspects of the PIP medical expense benefit that were specifically authorized by AICRA – utilization review and certain network benefits. Failure to follow the utilization review provisions or going out of the approved networks results in the penalty co-payments established by the rule. Insurers can provide other services to their insureds to get the most out of their claim dollar that do not involve penalty co-payments and so are not covered by the rule. Another example of this type of benefit to policyholders is the PPO discounts upheld by the Appellate Division in Seaview Orthopedics v. National Healthcare Resources, 366 N.J. Super 501 (App. Div. 2004).

N.J.A.C. 11:3-4.8(b)

COMMENT: Several commenters expressed the opinion that permitting networks for electrodiagnostic testing and, in particular, networks for needle EMGs, would be disruptive to

patient care since the person performing the test has no knowledge of the patient's underlying symptoms and would not be seeing the patient for follow-up.

Another commenter noted that physicians commonly refer to others with whom they have established a professional rapport. A network would disrupt these relationships and hurt patient care. One commenter recommended that, if networks for electrodiagnostic testing are permitted, physicians who are certified by the Board of Electrodiagnostic Medicine or by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association be permitted to perform the testing without incurring an out of network penalty.

RESPONSE: The Department recognizes that a patient who needs one of the electrodiagnostic tests listed, needle EMGs, might benefit from a more personal relationship with the physician performing the test because it requires the insertion of needles. Therefore, in response to the comments, the Department is amending the rule upon adoption to permit a treating physician to perform needle EMGs without incurring the out of network penalty if the treating provider is qualified to perform the test. Concerning the suggestion that the rule require certain professional qualifications for persons who do needle EMGs, the change requested by the commenter would be a substantive change requiring additional notice and public comment. The Department will review the qualifications of providers in any network that is qualified to be used for auto insurance in accordance with this rule and evaluate the experience in the administration of needle EMG's by in-network providers. If it is concluded that additional rulemaking is necessary, the Department will amend the rules.

COMMENT: One commenter stated that networks do nothing more than lower the payment ceilings for providers and keep insurers from paying the fee schedule amount, whether the provider is in or out of the network.

RESPONSE: The Department does not agree with the commenter. Insurers are required to pay the usual, reasonable and customary fee of the provider or the amount specified in the fee schedule, whichever is less. The fee schedule is the maximum permitted reimbursement, not the amount that should be paid. If providers contract to be a part of a network for a certain fee, that is their usual and customary fee for that service and is the appropriate level of reimbursement.

COMMENT: One commenter supported the Department in limiting the use of voluntary networks to certain high cost tests and durable medical equipment. The commenter believed this benefited consumers in helping to control costs.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter expressed the opinion that the requirement in N.J.A.C. 11:3-4.8(d)5 that requires that MRI facilities in networks be accredited by the American College of Radiology (ACR) is too stringent. The commenter stated that in a survey it conducted of MRI facilities, only 40 percent were accredited by the ACR. The commenter believed that this accreditation standard should not be mandatory and suggested that the rule recommend that MRI providers obtain ACR accreditation.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

COMMENT: One commenter opposed the imposition of voluntary networks in any form since they unfairly restrict the access of injured parties to necessary medical care. The commenter recommended that N.J.A.C. 11:3-8 be removed in its entirety from the proposal.

RESPONSE: The Department does not agree with the commenter. The networks provided for in the rule will enable insureds to maximize their claim dollars by ensuring quality care at negotiated discount prices. However, insureds that choose not to use the insurer's networks can still go to any provider they wish.

COMMENT: Several commenters suggested that the services for which voluntary networks may be used as set out in N.J.A.C. 11:3-4.8(b) include: transportation networks; hospital care networks; and physical therapy networks.

RESPONSE: At the outset, the Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, the Department does not agree with the commenter that the list of permitted networks should be expanded as suggested by the commenter. The Department has not permitted insurers to have networks for services for treatment such as physical therapy or hospitals. The Department believes that insureds should have the ability to choose their own treatment providers where a personal relationship may be important. The Department will study whether transportation networks should be added to the list and requests that insurers supply more information about how these networks would operate.

COMMENT: One commenter requested clarification as to whether the certification requirements for voluntary networks in N.J.A.C. 11:3-4.8(b) apply to an insurer or its vendor.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process. N.J.A.C. 11:3-4.8(d) makes it clear that the network may be used directly by an insurer or by the insurer's PIP vendor.

COMMENT: Several commenters recommended the development of an "any willing provider" provision in the network rule that would require insurers to include in an existing network any provider or facility that was willing to accept the network's compensation and abide by its other administrative rules. The commenters believed that such a provision would provide patients in under-served areas better access to diagnostic procedures.

One commenter recommended that participation in voluntary networks should be open to any provider that meets the qualifications in N.J.A.C. 11:3-4.8. The commenter also recommended that insurers be required to allow all qualified facilities to participate in a network if they are willing to accept the network fee. Likewise, non-participating facilities should be permitted to accept the negotiated network fee in lieu of the 30 percent co-payment.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

COMMENT: One commenter requested clarification as to whether the limitation on networks to "non-emergency" services applies to inpatient services provided at a rehabilitation hospital.

RESPONSE: It was not the Department's intention to require that a patient admitted to a rehabilitation or other non-acute care hospital be penalized for going out of network if the

diagnostic testing necessary for the patient is provided by the hospital and the hospital is not part of the insurer's network. The Department will examine this issue further and determine if additional rulemaking is necessary.

N.J.A.C. 11:3-4.8(c)

COMMENT: One commenter requested the following changes to N.J.A.C. 11:3-4.8(c): (additions in boldface, deletions in brackets) "Upon request and upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall [provide] **make available** to the injured person [a list of] **information about its** approved networks and [a current directory of] **the** providers in the network, including addresses and telephone numbers. The information may be made available via e-mail. Insureds shall be able to choose to go to any provider in the network."

The commenter also requested that DOBI explain the phrase "upon request and upon receipt." Are both criteria required, or is either sufficient alone, to trigger the requirements under this subsection? Another commenter requested that the treating physician also be provided with the list of network facilities so that he or she can advise the injured person.

RESPONSE: The Department agrees in part with the commenter's suggestion and has amended the rule upon adoption to substitute "make available" for "provide" and to substitute "information about" for "directory." This will give the insurer or its vendor more flexibility in making this information available. The Department also agrees that the phrase, "upon request and upon receipt," is somewhat unclear. The rule has been amended upon adoption to require that information about an insurer's voluntary network be **made available** to an insured **and a** treating provider upon notification of claim. N.J.A.C. 11:3-4.8(c)1 already requires that

information about the insurer's networks be provided to the insured when the policy is issued and upon renewal. Finally, the rule is being amended upon adoption to substitute "insured" for injured person. An injured person who is covered by the policy is an insured.

COMMENT: One commenter agreed that patients should be knowledgeable about the participating providers in a voluntary network. The commenter noted, however, that provider participation in a network can change frequently and it can be difficult to maintain accurate, hard copy directories. The commenter recommended that networks be allowed to offer directories via the World Wide Web or through telephonic access and that to assure that patients have the most timely information, networks be required to update directories every 30 days.

RESPONSE: As noted in the Response to a previous Comment, the Department has amended the rule upon adoption to require that the insurer make information available to the insured that includes provider information. This will allow insurers flexibility to provide the necessary information to insureds.

COMMENT: Several commenters recommended that, in addition to the insurer or the PIP vendor, the network be permitted to provide the information required by N.J.A.C. 11:3-4.8(c)2. The commenter also suggested that the information about available network facilities be limited to the geographic region where the insured person resides. This would eliminate the costs of distributing unnecessary information about MRI facilities in Cape May County to someone in Sussex County.

RESPONSE: The reference to insurers providing the information is not intended to preclude the network itself from communicating with the insured. The insurer is responsible for getting the

information to the insureds and details of its notification process should be included in its decision point review plan. As noted in the Response to a previous Comment, the Department has amended the rule upon adoption to require that the insurer make information available to the insured that includes provider information. This will allow insurers to send geographically relevant information.

COMMENT: One commenter objected to the requirement in N.J.A.C. 11:3-4.8(c)1 that insurers provide information about their voluntary networks to insureds at application and upon renewal. The commenter believed that this would only complicate the already overburdened application process. The commenter also believed it was not necessary to inform insureds about the insurer's networks at renewal unless there had been a change in the types of benefits for which it has voluntary networks.

RESPONSE: The Department does not agree with the commenter. It is not necessary that the information about its networks distributed at policy issuance and renewal be as detailed as when a claim is filed. It is important that the insured be provided this basic information about the insurer's claim handling practices.

N.J.A.C. 11:3-4.8(d)4

COMMENT: One commenter suggested that instead of the information required by N.J.A.C. 11:3-4.8(d)4, an insurer could provide its agreement with the network, as it would contain the required information.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.8(d)4, which requires disclosure of the financial arrangement between insurers and individual providers, goes beyond standards for other networks including Workers Compensation Managed Care Organizations and is inappropriate in this context.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

N.J.A.C. 11:3-4.8(d)5

COMMENT: One comment suggested that the Department amend number 5 in the list of informational items that must be included in an insurer's certification to DOBI concerning the insurer's use of a voluntary network or networks pursuant to N.J.A.C. 11:3-4.8(d), as follows: (additions in boldface): "Evidence that providers in the network maintain licensure, certification and adequate malpractice coverage. **All** MRI facilities in networks shall be accredited by the American College of Radiology (www.acr.org/)." In addition, the commenter requested that the Department also impose these licensure, certification, malpractice, and accreditation requirements on all MRI facilities that are out-of-network. Another commenter asked why the requirements governing malpractice coverage, accreditation, quality assurance programs, basic organizational documents and audited financial statements are not required of all providers of

PIP benefits before they can receive reimbursement for treatment of persons injured in automobile accident. Another commenter recommended that N.J.A.C. 11:3-4.5(b)5 be amended to require that all MRI facilities be accredited.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

COMMENT: One commenter noted that there are a number of diagnostic imaging facilities that are not required to be licensed by the Department of Health and Human Services but have been "grandfathered" under previous legislation. The commenter requested clarification as to how these facilities would be precluded from admission in a voluntary network under the new rule.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

COMMENT: One commenter recommended that, as an alternative to requiring accreditation of MRI facilities by the American College of Radiology, N.J.A.C. 11:3-4.8(d)5 also permit facilities to be accredited by the Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

COMMENT: One commenter noted that N.J.A.C. 11:3-4.8(d)5 requires malpractice insurance coverage for providers in a network at certain levels, some of which are higher than those currently required of licensed providers in New Jersey. The commenter stated that some providers in a network may not have malpractice insurance at these levels. The commenter recommended that a network be able to specify in its contract with the insurer that it will only use the providers in its network that meet the malpractice requirement.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

N.J.A.C. 11:3-4.8(d)7

COMMENT: One commenter suggested that N.J.A.C. 11:3-4.7(d)7 be amended upon adoption to eliminate the requirement that the provider directory for a network be submitted as part of the certification process. The commenter noted the expense of producing such a directory and observed that it would be out of date almost as soon as it was printed and suggested permitting alternate methods of disseminating this information to claimants. The commenter also suggested replacing “injured persons” in that section with “claimants.”

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

N.J.A.C. 11:3-4.8(d)8

COMMENT: One commenter believed that there was an editorial oversight in the use of the term "network" in the sentence: "The access standard shall not apply if the network demonstrates that there are one or no network facilities within that distance." The commenter suggested that "appropriate" be substituted and that otherwise the standard has no meaning. The commenter also suggested that "injured person" be substituted for "insured" in the previous sentence, "Sufficient access means a network facility within 10 miles or 30 minutes driving time of the insured."

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

COMMENT: Many commenters objected to N.J.A.C. 11:3-4.8(d)8, which requires that an insurer "demonstrate that the network provides sufficient geographic access to services." This is defined as "a network facility within 10 miles or 30 minutes driving time of the insured (or public transit, if available), whichever is less." N.J.A.C. 11:3-4 4.8(d)8 proposes that distance and driving time be computed using www.mapquest.com. One commenter objected to the definition and to the proposed use of www.mapquest.com because they impose an undue burden on insurers and on networks. The commenter recommended that insurers be allowed to identify networks by zip codes instead. Another commenter suggested that insurers be prohibited from applying the penalty deductible if an injured person demonstrates that the network does not have a facility within 10 miles or 30 minutes from the residence or place of employment of the insured. Alternatively, this commenter suggested that the access standard should be met if the

insurer has one or more facilities in every county of the State. Another commenter stated that in rural areas, few if any medical facilities may be within either the time frame or distance criteria, since in these areas there are very few providers available. The commenter also noted the bad traffic conditions in many part of New Jersey and suggested that 20 miles and 45 minutes would be a more reasonable standard.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

COMMENT: One commenter requested clarification on what criteria would be acceptable for: the network's quality assurance program required by N.J.A.C. 11:3-4.8(d)9 and the network's standards for selecting providers pursuant to N.J.A.C. 11:3-4.8(d)6. The commenter also requested clarification from the Department as to what would be an acceptable form of the complaint and grievance system required by N.J.A.C. 11:3-4.8(d)10.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

N.J.A.C. 11:3-4.8(d)12

COMMENT: Several commenters objected to the requirement that audited financial statements be provided as part of the requirements for certification as a voluntary network at N.J.A.C. 11:3-4.8(d)12. Some commenters pointed out that the networks bear any financial risk and that such a requirement is onerous and does not provide any guarantee of financial health. The commenter

requested that if the requirement for financial statements is retained, that they be regarded as confidential. Other commenters questioned the relevancy of this information.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

N.J.A.C. 11:3-4.8(d)13

COMMENT: Several commenters requested that N.J.A.C. 11:3-4.8(d)13 be amended upon adoption to include networks that are certified as part of a workers compensation managed care organization. The commenter noted that these organizations are subject to rigorous licensing requirements. One commenter also suggested that networks that are URAC accredited be subject to the lesser certification process, as they have already gone through a rigorous certification process.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process. The rule has been amended upon adoption to accept a network that is certified as part of a workers compensation managed care organization in place of the separate certification process handled by the Department. The Department is not sufficiently familiar with the URAC accreditation process to include it in the list of acceptable networks.

N.J.A.C. 11:3-4.8(d)

COMMENT: One commenter noted that, as a result of a typographical error, the regulation as proposed had two subsection (d)s of N.J.A.C. 11:3-4.8.

RESPONSE: The commenter is correct. Upon adoption, the erroneously identified subsection has been codified as subsection (e) and, as was discussed above, subsections (e) through (g) as proposed are not being adopted, as the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8, which required a separate network certification process.

COMMENT: One commenter requested that the word "voluntary" should be deleted from of N.J.A.C. 11:3-4.8(d) (recodified as (e)) so that it applies to all networks.

RESPONSE: The Department does not agree with the commenter. "Voluntary network" is the term used for networks permitted to be used by insurers in their decision point review plan. The Department does not know to what other networks the commenter is referring.

COMMENT: One commenter requested that, in addition to the requirement that networks be required to disclose a list of their clients to providers upon request, networks also be required to notify providers in writing each time a new client that would have access to the discounted rate joins the network.

RESPONSE: The Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. In addition, the Department believes that such a requirement would be a costly and unnecessary burden on a network. The rule as proposed gives providers the ability to determine, by making inquiry, which payors qualify for the discounted network rate.

N.J.A.C. 11:3-4.8(e)

COMMENT: Several commenters suggested that a dispute resolution process be added to N.J.A.C. 11:3-4.8(e) in the event that a challenge is necessary in response to the Commissioner's assessment that the certification application was deficient.

RESPONSE: As noted above in response to another comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

COMMENT: One commenter recommended that the Department specify in the rule that companies may continue using the networks already in place while the new certification process outlined in this regulation is being implemented.

RESPONSE: As noted above in response to another Comment, the Department has determined not to adopt those parts of N.J.A.C. 11:3-4.8 which required a separate network certification process.

N.J.A.C. 11:3-4.8(f)

COMMENT: One commenter requested that the Department add to N.J.A.C. 11:3-4.8(f) the decision of the Commissioner that PPO discounts for voluntary network providers are inappropriate.

RESPONSE: The Department does not know to what decision the commenter is referring. The Appellate Division recently issued a decision that upholds the use of PPO discounts in auto insurance. (Seaview Orthopedics v. National Healthcare Resources, 366 N.J. Super. 501 (App. Div 2004.)

N.J.A.C. 11:3-4.9

COMMENT: Several commenters suggested that the phrase, "but not limited to" be omitted in the following sentence, "Reasonable restrictions may include, but are not limited to:…" The commenter believed that the sentence creates ambiguity and will promote litigation.

RESPONSE: The Department does not agree with the commenters. N.J.S.A. 39:6A-4 prohibits the assignment of PIP benefits except to providers in accordance with policy provisions approved by the Commissioner. Prior to the proposed amendments, the rule simply gave insurers the ability to impose reasonable restrictions on the assignment of benefits. Such restrictions had to be approved by the Department in the insurer's decision point review plan but there was no other guidance for insurers. The amendments proposed by the Department not only clarify that an insurer cannot outright prohibit the assignment of benefits but provide examples of the restrictions that have been approved. Insurers still have the ability to propose other restrictions on assignment of benefits that would be subject to the Commissioner's approval.

COMMENT: Several commenters suggested that the list of acceptable restrictions on assignment of benefits include requiring the provider to use the insurer's internal appeal process prior to submitting the matter to alternate dispute resolution pursuant to N.J.A.C. 11:3-5. The commenter believed that such a change would give the insurer notice of the dispute and provide an opportunity to resolve the matter without incurring the expense of alternate dispute resolution.

RESPONSE: The Department notes that the change requested by the commenter would be a substantive change requiring additional notice and public comment. As noted above in response to the previous Comment, the list of acceptable restrictions in the rule is not intended to be

comprehensive. An insurer is not prohibited from including the restriction suggested by the commenter in its Decision Point Review plan filing with the Department.

N.J.A.C. 11:3-4.10

COMMENT: One commenter did not support the repeal of N.J.A.C. 11:3-4.10 and recommended that the reporting requirement in the rule be maintained to provide evidence that the rules are furthering the goals of the Legislature.

RESPONSE: The Department wants to measure the effectiveness of PIP reforms but does not agree with the commenter that the reporting formerly required by the rule provides the information that the commenter contends it did. Insurers were required to report on the number of decision point review and precertification requests received and the number approved and denied or modified. Most insurers reported similar results. The reports were not helpful in identifying problems with the administration of the Decision Point Review plans. The Department believes that analysis of complaints received, meetings with the Personal Injury Protection Technical Advisory Committee and other industry groups is a better method of monitoring the effectiveness of the PIP reforms than the reports.

N.J.A.C. 11:3-25.5(d)

COMMENT: One commenter supported the amendments to N.J.A.C. 11:3-25.5(d) that exempt providers from the penalties for failure to supply the 21-day notice if alternate forms of notice have been provided.

RESPONSE: The Department appreciates the support.

N.J.A.C. 11:3-5.6

COMMENT: One commenter requested that the insurer should be required to identify an appropriate contact person with telephone and fax number in addition to the address required in the proposal.

RESPONSE: The Department does not agree with the commenter. The purpose of the single address requirement is not to provide a contact person at the insurer for issues involving arbitration. The purpose is to ensure that filings for arbitration that are made after the provider has tried and failed to resolve the matter with the insurer are made to one address, in order to facilitate the process for claimants and the insurer.

COMMENT: Several commenters recommended that N.J.A.C. 11:3-5.6 be amended upon adoption to address some of the problems that carriers experience with respect to arbitration. These include: bills that are part of an arbitration filing although the carriers have not received copies of bills prior to the filing of the arbitration; premature filings for arbitration at the expense of the insurers; and demands for an exorbitant amount of attorney fees when there is little or no work performed prior to settlement.

RESPONSE: The Department notes that the changes requested by the commenters would be a substantive change requiring additional notice and public comment. The Department recognizes that these issues need to be addressed and notes that it specifically requested that bidders for the Dispute Resolution System administrator contract address several of these issues in their bids. The Department will work with the new administrator, National Arbitration Forum, and users of the system to reduce the number of arbitrations filed where there is no real dispute. If necessary, the Department will also do additional rulemaking to address the problem.

COMMENT: One commenter believed that setting the fee for an MRO from $900.00 to $575.00 would reduce the already low quality of the reviews provided and gave the opinion that the MRO process is a failure. The commenter stated further that if the Department wanted to continue with the MRO process, reviewing physicians should be precluded from performing any work for or on behalf of insurers writing auto insurance in this State. The commenter advised that conflicts of interest for the reviewers should be avoided.

RESPONSE: The Department does not agree with the commenter. Under the current rule, an MRO can set its own fee and those fees vary from $500.00 to $900.00. The Department believes that it can obtain a quality product at the fee established in the rule. Concerning conflicts of interest, N.J.A.C. 11:3-5.10(c)8 already requires MRO applicants to disclose contractual relationships with insurers so as to avoid conflicts of interest.

COMMENT: One commenter objected to the proposal imposing a fee of $575.00 for a medical review as part of an arbitration. The commenter believed this fee was excessive and would discourage use of the MRO. Another commenter questioned whether $575.00 was the most appropriate fee and recommended that the fees be kept within the current range of dispute resolution filing fees of $325.00 to $375.00. Another commenter questioned how the $575.00 fee can be justified when some MROs were currently charging less than that amount.

RESPONSE: The Department notes that the effect of adopting the proposal would be to lower most of the fees charged for MRO examinations, as two existing MROs currently charge higher fees. The fee in the proposal was determined by taking the fee of the MRO with the lowest fee and adjusting it for inflation.

COMMENT: Several commenters objected to N.J.A.C. 11:3-5.11, which allows the Commissioner to adjust the fee charged by an MRO for a medical review by order. The commenter stated that the current fee for the use of the MRO is $75.00 and believed that this is still too high to encourage usage by the parties and should be reduced to reflect the relative cost of the medical specialists being engaged to conduct the review. The commenter recommended that this provision be amended to allow the industry an opportunity to provide public comment on the Commissioner's intention to adjust the initial fee.

RESPONSE: The Department does not agree with the commenters. The fees for the current MROs range from $500.00 to $900.00. Thus, the effect of the proposed amendment will be to reduce the fee for some users. Medical costs can be subject to rapid inflation and the Department needs the ability to adjust the fees for the MRO examinations without need for a rule change. The fees will be adjusted by a Notice of Administrative Change published in the New Jersey Register. N.J.A.C. 11:3-5.11 has been amended upon adoption to include this requirement.

COMMENT: One commenter supported the establishment of the fee for an MRO review but recommended that the medical fee schedule fees be reviewed every two years and adjusted in accordance with the medical component of the Consumer Price Index.

RESPONSE: The commenter's suggestions are beyond the scope of this proposal.

N.J.A.C. 11:3-25.5

COMMENT: One commenter expressed agreement with the exemption from the 21-day notice requirement when alternative notice, such as a decision point review or precertification request have been received.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter asked whether the 21-day notice rule is eliminated by this proposal.

RESPONSE: The 21-day notice rule was established by statute and cannot be eliminated by rule. The amendment to N.J.A.C. 11:3-25.5 only provides that an insurer cannot impose late notification penalties if a provider has submitted a decision point review or precertification request. It does not eliminate the requirement that such providers give the 21-day notice. In addition, for treatment and testing that are not covered by decision point review or precertification, the 21-day notice requirement is still the means by which insurers are made aware that such treatment or testing has been initiated.

COMMENT: One commenter suggested that N.J.A.C. 11:3-25.5(d)4 be amended upon adoption to read, (additions in boldface) "When the provider has submitted a request for decision point review or precertification of treatment or testing **prior to treatment or testing** in accordance with an insurer's decision point review plan approved in accordance with N.J.A.C. 11:3-4."

RESPONSE: The Department does not agree with the commenter's suggestion. The existing text in the rule that requires the notification to be "in accordance with the insurer's decision point review plan." Decision point review plans require that decision point review plan or precertificaton requests be made prior to the treatment or test being performed. The whole point of the plans is to give insurers the opportunity to prospectively review the treatment or testing

that providers intend to perform. Therefore, the Department believes that the commenter's suggested language is superfluous and unnecessary.

COMMENT: One commenter suggested that N.J.A.C. 11:3-25.5(d)4 be amended upon adoption to read (additions in boldface), "When the provider has submitted a request for decision point review or precertification of treatment or testing in accordance with an insurer's decision point review **plan (and either is for treatment that is medically necessary as determined by the insurer)** approved in accordance with N.J.A.C. 11:3-4."

RESPONSE: The Department does not agree with the commenter's suggestion. The purpose of the additional exemption for penalties for failure to submit the 21-day notice is that the insurer has notice that treatment is contemplated or has commenced. Whether the insurer determines that the request for treatment or testing is medically necessary is irrelevant.

Summary of Agency-initiated changes:

The Department is amending N.J.A.C. 11:3-5.11 upon adoption to provide that the adjustment of the fee charged by an MRO for a medical review be published in the New Jersey Register as a notice of administrative change. The Department is amending N.J.A.C. 11:3-4.7(c)2 upon adoption to correct the inadvertent omission of "diagnoses" from the second sentence. The second sentence should repeat the list of items from the first sentence.

Federal Standards Statement

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

Full text of the adopted amendments and new rules follows (addition to proposal indicated in boldface with asterisks *__thus__*; deletion from proposal indicated in brackets with asterisks *[thus]*):

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

11:3-4.2 Definitions

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

. . .

"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.***

. . .

11:3-4.4 Deductibles and co-pays

(a) – (c) (No change .)

(d) Failure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment *[or]* *, ***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***,****[or]* ***diagnostic*** test ***or durable medical equipment***.

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

(g) For the purpose of the co-payments permitted in (d), (e) and (f) 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***. Such amount may have already been reduced by the application of the co-payments and/or deductibles in (a) and (b) above.

(h) (No change from proposal.)

11:3-4.7 Decision point review plans

(a) No insurer shall impose the co-payments permitted in N.J.A.C. 11:3-*[4.7(d), (e) and (f) above]**4.4(d), (e) and (f)* unless it has an approved decision point review plan.

1. (No change from proposal.)

(b) No decision point or precertification requirements shall apply within 10 days of the insured event or to *[treatment administered in]* 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. PIP vendors shall designate a New Jersey licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that decision point review and precertification requests are *[handled]* ***based upon medical necessity*** in accordance with the requirements of this subchapter.

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.

3. (No change from proposal.)

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 *[reimbursement]* ***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 *[decision]* ***denial*** shall be by a dentist;

5.-7. (No change from proposal.)

8. The *[certification]* ***information*** required in order to use a network pursuant to N.J.S.A. 11:3-4.8***(d)***, if applicable.

(d) (No change from proposal.)

1.-3. (No change from proposal.)

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 *[working]* ***business*** days; ***[and]***

[ii. If the insurer fails to respond to a request for decision point review/precertification within the timeframes called for in its plan, the treatment or testing may proceed until the insurer notifies the provider that reimbursement for the treatment or testing is not authorized;]

5.-7. (No change from proposal.)

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

9. (No change from proposal.)

(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*,**[or]* *diagnostic* test *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 ,**[or]* *diagnostic* tests~~ing~~ *or durable medical equipment* will be denied for failure to appear at scheduled medical examinations.

2.-5. (No change from proposal.)

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*,**[or]* *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 of reimbursement for treatment*,**[or]* *diagnostic* testing *or durable medical equipment* after repeated unexcused failure to attend a schedule*d* 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*,**[or]* ***diagnostic testing or durable medical equipment*** requiring precertification. In addition, the insurer may provide that reimbursement for treatment*,**[or]* ***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*,**[or]* ***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 *[fraudulent information]* ***the request involved fraud or misrepresentation, as defined in N.J.A.C. 11:16-16.2,*** *[was submitted]* by ***the provider or*** the person receiving ***the*** treatment*,* ***diagnostic testing or durable medical equipment*** *[or the provider or there was no coverage in effect]*.

11:3-4.8 Voluntary networks

(a) No insurer shall file a decision point review plan utilizing a voluntary network or networks unless the *[insurer or its PIP vendor has entered into such arrangements directly with

providers or has contracted with a network or networks.]* * **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 8:38A-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 or 8:38B.***

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

1.-2 (No change from proposal.)

3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 ***except for needle EMGs performed by the treating physician***;

4.-5. (No change from proposal.)

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

1. (No change from proposal.)

2. Upon *[request and upon]* receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall *[provide]* ***make available*** to the *[injured person a listing]***insured and the treating medical provider information about*** approved networks and *[a current directory of]* 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 *[a certification to the Department containing]* the following information ***[and documentation:]****to the Department with its Decision Point Review Plan:**

1. (No change from proposal.)

2. *[A statement that the insurer or its PIP vendor is either contracting directly with providers, or is contracting with a network or networks. In the latter case, the insurer shall include the following:

i.]* The identity and a description of the network and the specific services or supplies to be provided by the network or networks; *[and

ii. A description of the relationship between the insurer or its PIP vendor and the network, and a copy of the contract between the insurer or its vendor and the network;]*

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.

***[**4. If the insurer or its PIP vendor is contracting directly with providers, a narrative description of the financial arrangements between the insurer or its vendor and the providers. If the insurer or its PIP vendor is contracting with a network, a narrative description of the financial arrangements between the insurer or its vendor and the network, including the manner in which the network compensates its providers, a flow diagram of the complete billing and payment cycle that includes all intermediary steps for each method of reimbursement used (for example, capitation, fee for service) from the time services are rendered until the provider is paid;

5. Evidence that providers in the network maintain licensure, certification and adequate malpractice coverage. MRI facilities in networks shall be accredited by the American College of Radiology (www.acr.org)

i. With respect to physicians, malpractice insurance shall be at least $1,000,000 per occurrence and $3,000,000 in the aggregate per year;

ii. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined by the Commissioner as sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year; and

iii. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

6. A description of the criteria and method the network uses to select providers, including any credentialing plan;

7. A copy of the provider directory for distribution to injured persons;

8. A demonstration that the network provides sufficient geographic access to services. Sufficient access means a network facility within 10 miles or 30 minutes driving time of the insured (or public transit, if available), whichever is less. The access standard shall not apply if the network demonstrates that there are one or no network facilities within that distance. Distances and drive time to be computed by a generally available driving directions service, such as www.mapquest.com. Pharmacy and durable medical equipment networks may substitute delivery service for physical locations.

9. A description of the network's quality assurance program. At a minimum, this shall include:

i. A clear description of how quality of care will be monitored and

controlled;

ii. The criteria used to define and measure quality;

iii. The criteria used to determine the success or failure of the quality assurance program; and

iv. A description of the staff and their qualifications that will be responsible for the quality assurance program;

10. A description of the complaint and grievance system available to providers, including procedures for the registration and resolution of grievances.

11. A copy of the basic organization documents of the network if the insurer is contracting with a network, including the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto, together with a copy of the bylaws, rules and policies or similar documents regulating the conduct of the internal affairs of the network; and

12. A copy of the network's audited financial statement most recent to the time of application if the insurer is contracting with a network.

13. If a network is currently certified for another insurer or approved as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37, documentation of such certification or approval may be substituted for the responses to questions (c) 5 through 12 above.]*

[(d)] ***(e)*** Any voluntary network *[certified]* ***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.

*[(e) The Commissioner shall review the certification and advise within 60 days of receipt as to whether the certification is incomplete or complete. An insurer whose certification is incomplete shall have 60 days from the receipt of notice from the Department to remedy the deficiency.

(f) The use of a voluntary network certified under this subchapter may be halted if the Commissioner determines that:

1. The voluntary network criteria set forth in this subchapter are not being met;

2. Payment for covered services provided under the voluntary network is not made in accordance with N.J.S.A. 39:6A-5g; or

3. Any false or misleading information is submitted by the insurer or its PIP vendor in its certification .

(g) Proceedings to revoke or suspend the certification shall be conducted pursuant to N.J.A.C. 11:17D.

1. Upon request of the network 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 the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.]*

11:3-5.11 Fees

(a) The initial fee for a determination by a Medical Review Organization shall be $574.00. The Commissioner may adjust the fee every two years by order based on the rise in the medical component of the Consumer Price Index as published by the United States Department

of Labor. *Such fee adjustments shall be initiated in this subchapter through a notice of administrative change published in the New Jersey Register.*

(b) (No change.)

11:3-25.5 Late notification

(a) – (c) (No change.)

(d) Insurers shall not reduce an eligible charge under the following circumstances:

1.-3 (No change from proposal.)

4. When the provider has submitted a request for decision point review or precertification of treatment*,* *[or]* ***diagnostic*** testing *or ***durable medical equipment*** in accordance with an insurer's decision point review plan approved in accordance with N.J.A.C. 11:3-4.7