

**INSURANCE**

**DEPARTMENT OF BANKING AND INSURANCE**

**OFFICE OF PROPERTY AND CASUALTY**

**Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests; Personal Injury Protection Dispute Resolution**

**Adopted Amendments: N.J.A.C. 11:3-4.2, 4.4, 4.7, 4.8, 5.4, 5.10 and 5.11**

Proposed: July 6, 2009 at 41 N.J.R. 2609(a).

Adopted: June 10, 2010 by Thomas B. Considine, Commissioner, Department of Banking and Insurance

Filed: June 11, 2010 as R. 2010 d.142, **with substantive changes** not requiring additional public notice and opportunity for 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, 39:6A-5.1 and 39:6A-5.2.

Effective Date: July 6, 2010

Expiration Date: June 7, 2011

**Summary** of Public Comments and Agency Responses:

The Department received timely comments from the following persons and organizations:

Marshall P. Allegra, MD

Bonnie Brady

New Jersey Society of Interventional Pain Physicians

New Jersey Association of Osteopathic Physicians and Surgeons

William deGasperis, Atlantic Imaging Group

Lawrence Downs, Medical Society of New Jersey

Wayne Fleischhacker, D.O.

Nona Garson

Dr. Glush

Gary Goldstein

Sean T. Hagan, Esq.

Jeanne Heisler: Independent Agents and Brokers of New Jersey

Fred Hipp, Jr., Virtua Health

David J. Karbasian, Esq.

David J. Klinger, Esq.

Todd Koppel, MD

Steve Lisner

Barry Liss, Esq.

Tony LoCastro

Steven Lomazow, MD

Beverly J. Lynch, NJ Society of Physical Medicine & Rehabilitation

Rachel Moore, Insurance Council of New Jersey

New Jersey Association for Justice

Arthur M. Pavluk, III

Alexander Pendino, D.O., Electrodiagnostic Medicine Association of New Jersey

Lee Pressler, MD

Harris M. Recht, Esq.

Shari A. Rivkind, Esq.

Janet M. Rizzo

John Rogers, Esq. Horizon Blue Cross and Blue Shield of New Jersey

Roger A. Sarao, New Jersey Hospital Association

Jeffrey Shanton

Leslie Shrem

Richard M. Stokes, Property Casualty Insurers Association of America

Curtis J. Turpan, Esq.

Phyllis Tutek, Center for Advanced Surgery and Pain Management

Alliance for Quality Care by Mark Manigan & John Fanburg,

Deborah Wean, NJM Insurance Group

David T. Wheaton, Esq.

Scott Woska, MD

COMMENT: One commenter representing a producer organization supported the Department's intention in the proposal to lower the overall cost of PIP benefits by waiving deductibles and copays when treatment is performed by providers in Organized Delivery Systems (ODS) contracted with the insurer. The commenter noted that PIP costs had increased in recent years. The commenter also believed that the proposed amendments to create an expedited hearing process for issues of medical necessity were reasonable.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter expressed support for the amendments permitting insurers to waive copayments and deductibles for treatment provided through an ODS. The commenter agreed that insureds would stretch their PIP benefits and insurers would contain costs through such arrangements.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter strongly supported the Department's proposed amendments to N.J.A.C. 11:3-4.8(b) (voluntary networks for ambulatory surgical centers (ASCs)) and to N.J.A.C. 11:3-4.4 (waiver of deductibles and copayments when an insured goes to a provider in an ODS). The commenter stated that treatment provided in voluntary networks is of high quality and the financial and administrative savings indirectly benefit insureds. The commenter asked that the rule be amended upon adoption to permit insurers to implement the ODS provision immediately without having to file policy language with the Department and wait for insureds to renew their policies.

RESPONSE: The Department appreciates the support. With regard to the request to amend the rule upon adoption, the change suggested by the commenter is substantive and would require additional notice and comment. Further, the Department believes that the provision permitting waiver of deductibles and copayments for treatment by a provider in an ODS should be contained in the policy language.

COMMENT: One commenter supported as "common sense," the proposed amendment at N.J.A.C. 11:3-4.7 prohibiting precertification requirements for the evaluation and management of new patients.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter supported the amendment to N.J.A.C. 11:3-5.4 to accelerate the conclusion of medical necessity disputes in cases where there is no issue of irreparable harm. The commenter noted that pain and limitation are not always associated with irreparable harm but it is not unreasonable for those suffering such ailments to expect timely attention.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters expressed support for the proposed amendment to permit insurers to waive the deductibles and copayments if insureds elect to receive treatment from an ODS. However, several commenters noted that the insurer may not contract directly with an ODS. There may be a third party, such as a PIP vendor, involved. The commenters asked the Department to amend the rule upon adoption to clarify that this is permissible.

RESPONSE: The Department agrees with the commenters and has amended N.J.A.C. 11:3-4.4 upon adoption to add that the waiver is permitted for ODSs contracted with the insurer or its PIP vendor. The Department notes that PIP vendor is already a defined term in the rule.

COMMENT: One commenter supported the proposed amendment to N.J.A.C. 11:3-5.4(b) codifying in the rule the existing standards for granting emergent hearings.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter stated his belief that N.J.A.C. 11:3-5.4(b)2 should be amended to permit consolidation of claims for arbitration at any time. The commenter noted that the rules of the Dispute Resolution Organization permit the consolidation of multiple cases by the same provider if they have been pending for less than 180 days. The commenter believed that this rule is contrary to the decision in *NJ Cure v. Collins*.

RESPONSE: The Department notes that N.J.A.C. 11:3-5.4(b)2 was not amended in this proposal. The Department also does not agree with the commenter that the decision in *NJ Cure v. Collins (New Jersey Citizens United Reciprocal Exchange v. Kieran Collins*, 399 N.J. Super. 40 (App. Div. 2008)), requires that consolidation be permitted at any time during a pending arbitration. Therefore, the Department does not believe that any future amendment to N.J.A.C. 11:3-5.4(b)2 is necessary. The commenter should pursue changes in the Dispute Resolution Organization's rules through its Advisory Council.

COMMENT: One commenter supported the amendments to N.J.A.C. 11:3-5.4(b) authorizing an expedited appeal to an medical review organization (MRO) on issues of medical necessity. The commenter requested that the rule be amended upon adoption to require that a demand for arbitration could only be made if the claimant had completed the insurer's internal appeal process. The commenter also requested that the fee for this expedited appeal be limited to encourage its use.

RESPONSE: The Department appreciates the support. The Department does not agree that the rule needs to be amended upon adoption to include the language suggested by the commenter. The provision in the rule only authorizes the expedited medical necessity

process. The details of such a procedure will be contained in the rules of the Dispute Resolution Organization. Concerning the fee for the MRO review of the expedited appeal, the Department will establish the fee as part of the implementation of this rule.

COMMENT: One commenter noted that the Department was establishing a new standard for the granting of emergent hearings. The commenter requested that an emergent hearing only be granted where the services in dispute have not been performed and where failing to approve future treatment would cause immediate and irreparable harm to the patient.

RESPONSE: The Department does not agree with the commenter that the adopted amendments create a new standard for emergent hearings. The emergent hearing standard requested by the commenter is the standard that is currently in effect. This standard for emergent hearings had been included in the Arbitration Administrator's rules for the conduct of arbitrations. The Department has determined that it is appropriate to incorporate the standard into its administrative rules governing arbitration.

COMMENT: One commenter objected to the addition of the "immediate and irreparable harm" standard for an expedited hearing in N.J.A.C. 11:3-5.4(b)3. The commenter believes that the language is inconsistent with the enabling legislation for PIP. Another commenter suggested that adding the "immediate and irreparable harm" standard was meaningless without further defining it. The commenter notes that the "immediate and irreparable harm" standard in the PIP Arbitration Administrator's rules is being challenged in the Appellate Division. The commenter believes that the definition of

“emergency personal injury protection coverage” in N.J.S.A. 39:6A-3.3(b)1 is what the Legislature intended to be the standard for a claimant seeking an expedited arbitration hearing.

RESPONSE: The Department does not agree with the commenters. In an opinion issued on March 25, 2010 in *Gonzalez v. New Jersey Prop. Liab. Ins. Guar. Ass'n*, 412 N.J. Super. 406 (App. Div. 2010), the Appellate Division upheld the Department’s position on the standard for requesting an emergent hearing that was previously only contained in the approved Dispute Resolution Plan. The court also found that “immediate and irreparable harm” was a standard with which everyone was familiar. In addition, the Department believes that the definition of “emergency personal injury protection” in N.J.A.C. 39:6A-3.3(b)1 is not relevant to issues related to PIP arbitration. The referenced statute establishes the Special Auto Insurance Policy for low income individuals.

COMMENT: In preface to specific comments on the proposal, one commenter stated that it took strong exception to the proposal and found it to be incompetent for its purpose and illegal in its provisions. The commenter went on to state that any analysis of a proposal should seek to determine whether the proposed amendments seek to enhance the current process or to undermine it. The commenter requested that the Department acknowledge that former Commissioner Goldman made statements acknowledging that delays in the processing of appeals of denials of requests for precertification of treatment or testing represented a serious problem in the system. The commenter alleged that statistics published by the Department and the National Arbitration Forum (NAF) demonstrate that there has been a vast expansion of the number of denials of requests for precertification



of treatment and testing by automobile insurers over the last couple of years. As evidence of this, the commenter noted that in calendar year 2008, there were 52,000 demands for arbitration filed with the PIP arbitration administrator, NAF, alone, plus an unknown additional number filed in Superior Court. The commenter alleged that arbitrations appealing the denials of medical treatment had more than doubled within the past five years and this had created a “vast backlog of petitions” that the current proposal did not adequately address.

RESPONSE: The Department does not agree with the commenter’s assertions. The Department has no record of any statement by former Commissioner Goldman that characterized the problem of denials of precertification of treatment alleged by the commenter as a serious problem. In a July 8, 2009 letter to the commenter responding to a request for an intermediate track in the arbitration system, former Commissioner Goldman said, “I appreciate that you brought this issue to our attention and we agree that it is something that we should address.” The Department also disagrees with the commenter’s statement that statistics published by the Department and NAF indicate that there has been a great increase in the denials of requests for precertification of treatment. The evidence of this provided by the commenter was the number of arbitration filings made in 2008. Claims can be submitted to arbitration for many different reasons, not simply denial of precertification. Neither the Department nor NAF collects any statistics on the number of precertification requests received or denied. Further, in a June 5, 2008 letter to the Department attached as an exhibit to the rule comment, NAF stated that, “[w]hile there are over 36,000 awarded cases, the Forum’s system does not include a searchable database of issues.”

COMMENT: One commenter described how it had presented its own suggestions for an intermediate track for medical necessity issues to the Department. The commenter stated that its intermediate track proposal was not adequately considered by the Department and was superior to the amendments to the rule proposed by the Department.

RESPONSE: The Department does not agree with the commenter. The Department conducted an extensive review of the commenter's suggested intermediate track procedure and determined to address the issue in a different manner.

COMMENT: Several commenters stated that the Department's proposed amendments do not meet the mandate of N.J.A.C. 11:3-5.4(b)5, which requires that the arbitration forum, "shall provide for prompt, fair and efficient resolutions of PIP disputes after a hearing by the assigned DRP, which may also include expedited hearings." The commenter points out that the proposed amendments addressing review by an MRO of medical necessity issues do not provide for a hearing by a DRP with the opportunity to confront witnesses, be represented by an attorney or present evidence. The commenter alleged that the proposed amendments, "give the MRO unbridled power to render final decisions that affect life and death, without the opportunity to be heard."

RESPONSE: The Department does not agree with the commenters and notes that the commenters did not quote N.J.A.C. 11:3-4.5(b)5 in its entirety. The rule provision reads, "5. The plan shall provide for the prompt, fair and efficient resolution of PIP disputes, after a hearing by the assigned dispute resolution professional, **but shall also provide that alternate procedures may be utilized when appropriate, which may include**

**mediation, conferences to promote consensual resolution and expedited hearings upon receipt of a medical review organization report, consistent with principles of substantive law and rules adopted by the Commissioner;”** (emphasis added).

The proposed amendments authorize such an alternate procedure whereby an insured whose request for medical treatment has been denied by an insurer can have a rapid review of that decision made by an MRO. This procedure, where the medical file is submitted to the MRO for a decision without a hearing or testimony, is very similar to that used for the Independent Health Care Appeals Program (<http://www.state.nj.us/dobi/ihcp.htm>) administered by the Department for medical necessity determinations by health insurers. If the MRO review does not resolve the issue, the claimant may continue with the standard arbitration procedure. N.J.A.C. 11:3-5.4(b)6 is being amended upon adoption to clarify that the claimant retains the option to do so.

COMMENT: A commenter stated that the proposed regulation is contrary to N.J.S.A. 39:6A-1 et seq., which requires that any PIP arbitration be decided by an arbitrator or DRP with the full opportunity of a petitioner to be heard. The commenter concluded that the proposed amendments were, “illegal, ultra vires and unconstitutional.”

RESPONSE: The Department does not agree with the commenter. As noted above in response to another comment, the proposed amendment does not permit persons other than DRP’s to make decisions in arbitrations. The amendment merely authorizes an alternative to the arbitration procedure whereby a rapid determination of a dispute about medical necessity can be made by an independent medical review organization.

Moreover, the claimant may proceed to full arbitration before a DRP if the expedited MRO review does not resolve the PIP dispute.

COMMENT: One commenter stated that under the proposal, MRO physicians would have the authority to make “findings of fact and conclusions of law” regarding issues of medical necessity. The commenter stated that the current regulations require that all legal determinations be made by a DRP.

RESPONSE: The Department does not agree with the commenter. As noted above in response to another comment, the procedure authorized in the proposed rule is an alternative to arbitration and does not authorize anyone other than a DRP to make findings of fact and conclusions of law in an arbitration decision. The Department notes that N.J.A.C. 11:3-5.8(a) already authorizes MROs to make determinations of medical necessity.

COMMENT: One commenter stated that it was unacceptable that the proposed amendments did not provide any limit or guidelines as to how the fee would be paid to the MRO for the review. The commenter also noted that the proposal did not allow for counsel fees for a successful claimant and stated that “it was unrealistic to expect persons facing life and death decisions and medical necessity issues which affect their very well being, to be able to obtain representation by counsel on such vital issues, without any provision for reimbursement of counsel fees to the prevailing party.”

RESPONSE: The Department does not agree with the commenters. First, the amendment only requires that the Arbitration Administrator’s Plan have a procedure for referral of

medical necessity disputes to an MRO. The Administrator's rules will contain the details of how the procedure will work, including fees and who will pay them. Second, the Department does not believe that the expedited submission of medical necessity disputes directly to an MRO for a determination upon the medical records necessarily requires attorney representation or reimbursement of counsel fees because of the "on the papers" procedure and the narrow issue under review. As with submissions to MROs under the current arbitration system and the Independent Health Care Appeals program mentioned above in response to another comment, medical necessity determinations are made on the basis of the medical records in the case.

COMMENT: One commenter stated that the provision of N.J.A.C. 11:3-5.4(b)6, which states that no attorneys' fees may be charged for the expedited MRO review of medical necessity decisions, violates Court Rule 4:42-9 and N.J.A.C. 11:3-5.6(d)3, which states that attorney fees are to be consonant with the award made to a successful claimant. Another commenter stated that the prohibition of attorney fees would be overturned by a court as being "ultra vires."

RESPONSE: The Department does not agree with the commenters. The awarding of attorney's fees to successful claimants in PIP arbitrations is permitted, but not mandatory under R. 4:42-9(a)(6), N.J.S.A. 39:6A-5.2(g) and N.J.A.C. 11:3-5.6(d)3. Although attorney's fees are often awarded to successful claimants for benefits under PIP, no statute, court rule or regulation requires the award of attorney's fees. Moreover, N.J.S.A. 39:6A-5.1 grants the Commissioner the power to promulgate rules and regulations with respect to the conduct of dispute resolution proceedings to ensure independence and

fairness of the review process. The Commissioner has determined that an expedited review process by MROs where testing or treatment has been denied as “not medically necessary” should be made available to all claimants without regard to the emergent relief standards because it will permit prompt treatment/testing when found to be medically appropriate by the MRO. As noted above in response to another comment, the determination by the MRO is not an arbitration award and such alternate procedures are specifically authorized by N.J.A.C. 11:3-5.4(b)5. In light of the expedited, “on the papers” procedure for this review by an MRO, the Department believes that an award of attorney’s fees is not warranted. If unsuccessful in the expedited MRO review, the claimant may proceed with full arbitration before a DRP and recover attorney’s fees as appropriate if ultimately successful.

COMMENT: One commenter stated that it was not clear that providers under an assignment of benefits may use the procedure. The commenter also suggested that insurers might use the expedited MRO procedure to cut off services for a patient without a physical examination.

RESPONSE: The Department does not agree with the commenter. The expedited MRO process is intended for patients and providers. The only limitation on who may utilize the expedited procedure is that the dispute must be about medical necessity of treatment or testing. Otherwise, anyone that can file an arbitration can use the procedure. Concerning insurers using the procedure, the Department notes that insurers do not file arbitrations against patients and providers. Insurers already have many alternatives to determine the medical necessity of treatment and testing.

COMMENT: One commenter asked for confirmation that the expedited MRO procedure in N.J.A.C. 11:3-5.4(b)3i was voluntary and the insured would still be able to have an arbitration hearing on issues of medical necessity. The commenter also asked what the mechanism would be to appeal an MRO decision.

RESPONSE: The expedited process to determine the medical necessity of treatment or testing proposed N.J.A.C. 11:3-5.4(b)3i is voluntary. As noted in the Summary of the proposal, it permits an insured to get a decision on an issue of medical necessity much more quickly than through an arbitration proceeding. The Department does not understand what the commenter is referring to concerning the procedure for appealing an MRO decision. Moreover, an insured would not be appealing an MRO ruling if he or she did not accept the decision rendered through the expedited process. The dispute would simply be assigned to DRP and the normal arbitration process would continue. As noted above, this procedure has been clarified in this adoption. Just like any other report by an MRO, the DRP can overcome the report issued by the MRO in the expedited case by a preponderance of the evidence. The rule amendment does not provide the procedure for this process, it simply authorizes it. The details of how the process works will be proposed in the rules of the Dispute Resolution Organization and there will be an opportunity for comment.

COMMENT: Several commenters requested that the details of how the expedited MRO procedure would work be proposed as administrative rules by the Department with an opportunity for public review and comment. The commenters posed a number of

questions about how the process would work and recommended that the Department not adopt this part of the proposal.

RESPONSE: The rule amendment at N.J.A.C. 11:3-5.4(b)6 does not provide the procedure for this process, it simply requires such procedures be included in a Dispute Resolution Organization's (DRO) Dispute Resolution Plan. The details of how the process works will be proposed in the rules of the DRO and there will be an opportunity for further comment.

COMMENT: One commenter who is a physician stated that he was concerned about the loss of the arbitration process as it currently exists. The commenter stated that his treatment of patients is routinely denied by Independent Medical Examinations performed by insurance companies. The commenter stated that he has no choice but to treat the patient and then arbitrate. The commenter requested that this option not be eliminated by having medical necessity determined by an insurance company's paid "medical necessity" examiner.

RESPONSE: The commenter has not understood the proposal. Under the proposal, a patient would have the option to have the medical necessity of a treatment or testing determined by an MRO instead of waiting months for an arbitration decision to be rendered. If the commenter performs treatments that are denied by the insurer and then arbitrates, his patients would not need to use the expedited procedure to determine the medical necessity of treatment or testing. The expedited procedure is designed for those situations in which the patient cannot get a treatment or test that has been denied by the insurer as not medically necessary.



COMMENT: One commenter questioned the necessity and/or utility of the expedited medical necessity review by an MRO. The commenter believed that the emergent relief process was sufficient and that, with the implementation of the fee schedule rule, the number of arbitrations should decrease and further reduce the backlog of cases.

RESPONSE: The Department does not agree with the commenter. The Department has been advised that there are many instances in which the refusal of treatment or testing does not rise to the irreparable harm standard for an emergent hearing, but that a delay in treatment or testing for the time it takes to conduct an arbitration has negative consequences on the recuperation of the patient. The proposed amendments provide a method to get a rapid determination of medical necessity in such instances. While the implementation of the fee schedule may decrease the number of arbitrations, the Department anticipates that it may still take several months for a consumer to get an arbitration decision.

COMMENT: One commenter opposed the proposed amendment authorizing an expedited medical necessity review by an MRO. The commenter stated her understanding that the amendment would permit an insurer to require a review of the patient's condition by an MRO that could not be arbitrated or refuted. The commenter also found it unacceptable that the proposal would permit a physician in a different specialty to cut off all treatment without regard to the opinion of the treating provider. The commenter believed that this would take away the due process normally required by law. Another commenter stated the amendment would effectively eliminate the provider's right to be

represented by counsel in disputes over recommended treatment. This commenter believed that the patient should be notified of the MRO review so that he or she can participate. The commenter also recommended that the MRO review have an appeal provision.

RESPONSE: The commenters misunderstood the proposed amendments. The expedited medical necessity review by an MRO would be requested by the patient or his or her provider, not the insurer. The MRO would make a rapid determination of the medical necessity of treatment or testing that the insurer had denied based on the medical information supplied to the insurer. The proposed amendment does not prohibit arbitration of the dispute if the insured does not agree with the finding of the MRO. Rather than taking away any due process as alleged by the commenters, the proposed amendments give injured patients another way to obtain the treatment or testing they desire when it has been denied by their insurer, and to do so on an expedited basis.

COMMENT: One commenter questioned the necessity for the amendments authorizing the expedited MRO medical necessity review. The commenter cited statistics from National Arbitration Forum, the current Dispute Resolution Organization, that only 57 requests for an emergent hearing were made out of more than 40,000 arbitration requests. The commenter stated that attorneys have an ethical duty to use existing laws and procedures to seek the appropriate administrative or judicial remedy for their clients. This indicated to the commenter that if only 57 requests for emergent relief were filed in 2007, then the problem of patients suffering adverse medical consequences by being denied treatment or testing is not at all common.

RESPONSE: The Department does not agree with the commenter. The proposed amendments authorizing the expedited MRO review of medical necessity are not directed at instances where the failure to get treatment or testing would result in immediate or irreparable harm. It is because of the difficulty of meeting that standard that the Department decided to propose amendments providing the alternative procedure. The expedited MRO medical necessity review permits patients with conditions that do not meet the emergent hearing standard to get a rapid determination of the medical necessity of their treatment or testing from an MRO, if they choose to seek such expedited relief under N.J.A.C. 11:3-5.4(b)6.

COMMENT: One commenter noted that in most cases where an insurer denies treatment or testing, the patient receives the treatment or testing anyway and an arbitration is filed to demand payment for treatment already performed. The commenter assumed that the proposed amendment authorizing an expedited MRO review of medical necessity was intended to apply to those rare instances where the provider refused to perform the treatment or testing unless he or she was assured that the insurer would pay for it. The commenter stated that, as proposed, the amendment does not make this distinction and that the amendment could apply to all denials of treatment or testing even if the arbitration is for payment for treatment already provided. The commenter stated that in such case, there would be a huge number of cases that would overtax the resources of the MROs.

RESPONSE: The Department does not agree with the commenter. The proposed amendment to N.J.A.C. 11:3-5.4(b)6 authorizing the expedited MRO review of medical

necessity was intended to apply only to those cases in which a patient is seeking to demonstrate the medical necessity of treatment or testing that has not occurred. This intent will be further clarified in the rules of the arbitration administrator implementing the provision. Therefore, the Department believes that it is unlikely the system will be overloaded with such requests.

COMMENT: One commenter asked if the Department is potentially shifting the primary responsibility in an auto related injury from the auto insurer to the patient's health insurer if MROs are repeatedly decided in favor of carriers. The commenter wondered if this would lead to an increase in the cost of health insurance.

RESPONSE: The Department does not understand the comment. As noted above in response to a previous comment, the amendment authorizes a new procedure whereby a person who has received a denial of treatment or testing due to lack of medical necessity may seek a rapid decision on the medical necessity of the treatment or test from an MRO, rather than waiting six months for a full arbitration decision from a DRP. Since the merits of the PIP carrier's denial based on a lack of medical necessity will be the same regardless of whether it is reviewed sooner through the expedited review process or later through a regular arbitration proceeding, the amendment in question should not have any effect on the cost of health insurance.

COMMENT: One commenter stated that the Department did not explain why it was not feasible to set the fees for MRO by rule. The commenter asked if the result could be that the MROs could have different fees. The commenter also noted that the providers in

MROs are the same ones that do Independent Medical Examinations (IMEs) and Peer Reviews for insurance companies. The commenter asked what would prevent insurers from pressuring MROs to lower their fees to the level where an MRO could be requested in every case.

RESPONSE: The Department does not believe that it is feasible to set fees for MROs by rule because it needs more flexibility to adjust fees than can be provided in the time it takes to amend a rule. It is possible that there could be different fees for different MRO reviews and this has actually happened in the past. While some of the providers in MROs may do IMEs and peer reviews for insurers, none of the MROs are controlled by insurers and insurers have no control over the fees charged for MRO reviews.

COMMENT: One commenter stated that it appeared that “Organized Delivery System” or ODS was just a new term for networks. The commenter stated that some clarification is necessary since the rule refers to an ODS in some places and ”network” in others.

RESPONSE: The Department does not agree that a clarification is necessary. An Organized Delivery System is a specific type of organization that provides medical services and is regulated by the Department. A “network” is defined in the rules as, “an entity other than an insurer that contracts with providers to render health care services or provide supplies at predetermined fees or reimbursement levels.” A network can include an ODS as well as other types of health care providers. N.J.A.C. 11:3-4.8(a) specifically states what types of provider organizations can be considered networks for PIP:

No insurer shall file a decision point review plan utilizing a  
voluntary network or networks unless the network is a

health maintenance organization licensed pursuant to N.J.S.A. 26:2J-1 et seq.; or approved by the Department as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37 and 11:24A-4.10; or approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6; or is licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 and 11:24B.

COMMENT: One commenter requested a clarification of whether the language in N.J.A.C. 11:3-4.4(d), "medical treatment from a provider that is part of an ODS," referred to the provider performing the procedure or the facility fee or both. The commenter assumed that the deductible and copayment would apply only to the facility fee. The commenter noted that the Department has a well established policy of not permitting networks for treating providers. The commenter also stated that it appeared that the waiver of deductible and copays only applied to ODSs that contain ASCs. Another commenter requested confirmation that the waiver of copays and deductibles only applied to care provided in networks approved for the use of PIP insurers.

RESPONSE: The commenters have confused two different provisions of the proposal. The amendments to N.J.A.C. 11:3-4.8 add ASCs to the types of networks with which insurers may contract. This means that if an insurer has such a network, an insured who goes out of network pays a penalty copayment. The proposed amendments to N.J.A.C. 11:3-4.4(d) would permit insurers to waive the statutory deductibles and copayments for

any kind of treatment performed by providers in an ODS that has contracted with the insurer, including but not limited to ASCs. The definition of ODS in N.J.A.C. 11:24B-1.2 is:

"Organized delivery system" or "ODS" means an entity with defined governance that contracts with a carrier to provide or arrange for the provision of one or more types of health care services to covered persons under a carrier's health benefits plan(s), whether under the base policy or a rider thereto, or that provides services that effect the delivery of one or more types of health care services, the quality or quantity of one or more types of health care services delivered, or the payment of benefits under a carrier's health benefits plan for one or more types of health care services received. The term "ODS" does not include a health care professional licensed or authorized to render professional services pursuant to Title 45 of the New Jersey Statutes, or similar laws in the jurisdiction in which the health care professional renders services; or, a health care facility licensed or authorized in accordance with Title 26 or Title 45 of the New Jersey Statutes, or similar laws in the jurisdiction in which the health care facility provides services.

The commenter is correct that the Department has not permitted insurers to impose a copayment penalty for failure to use a network of treating providers. The proposed amendments to N.J.A.C. 11:3-4.4(d) similarly do not penalize insureds for going out of a network. The amendments permit an insurer to offer an incentive to use a provider in an ODS by waiving the statutory copayments and deductibles for such treatment.

COMMENT: One commenter stated that the term “ODS access fee” requires further clarification. The commenter noted that the term is not defined in the rule.

RESPONSE: An ODS access fee is the fee that an insurer pays to an ODS for the use of its provider network.

COMMENT: One commenter stated that the inclusion of the ODS access fee in policy limits as proposed in N.J.A.C. 11:3-4.4(d)2 is riddled with infirmities and that the benefit to insureds is potentially, if not completely, illusory. The commenter asked what “included within policy limits” means. If the intent is to increase the amount of medical expense benefit available to the insured, the commenter suggested that raising policy limits would be better public policy. The commenter doubted whether any provider’s charges exceeded \$10,000 and doubted the relevance of this part of the proposal.

RESPONSE: The Department does not agree with the commenter. This part of the proposal is directed to insurance companies and is based on a practice previously used by the Unsatisfied Claim and Judgment Fund that, as part of its reimbursement to insurers of Excess Medical Expense Benefits, audited bills in excess of \$10,000 and permitted insurers to include the access fee for such bills in policy limits. This provided an



incentive for insurers to utilize the ODS discounts in higher value claims. Normally, the fee paid by the insurer for access to the ODS network is part of the cost of handling the claim and not included in the policy limits.

COMMENT: Several commenters stated that an insurer ought to be able to charge the access fee for an ODS against the liability limit regardless of the size of the bill. The commenter believed that limiting this ability to bills greater than \$10,000 would prejudice an insured who had several bills that together totaled \$10,000. The commenter also stated that administration of the application of the access fee would be administratively extremely burdensome.

RESPONSE: The Department does not agree with the commenter. The insured gets the same benefit – waiver of deductibles and more treatment for their claim dollar regardless of whether the ODS access fee is included in the policy limits. The purpose of permitting the inclusion of the ODS access fee in the policy limits is to give a benefit to insurers for having higher-value treatments performed by an ODS. The Department will monitor the use of the provision to determine whether the administrative burden of the process outweighs its advantages to insurers and may make adjustments to the practice in future rulemaking.

COMMENT: One commenter stated that the proposed amendments to N.J.A.C. 11:3-4.4(d) and 4.8 would create an additional set of economic incentives intended to direct patients to obtain physician services from providers in the auto insurer's physician

network. The commenter believed that these changes would make more patients select physicians based on economics rather than quality and this would disproportionately affect those with less ability to pay for out-of-network care. The commenter stated that some patients would have to choose between paying less for a physician in their auto insurer's network and paying more for a physician in their health insurer's network, which would result in fragmentation of care and lower quality of care provided.

RESPONSE: The Department does not agree with the commenter. It is likely that a provider who is in a health payor's network would also be in an auto insurer's network. The provisions of the rules are intended to encourage participation by providers in networks so as to contain costs of PIP benefits and to stretch policyholders' claims dollars.

COMMENT: Several commenters stated that many insurers have arrangements with entities that provide health care services but are not ODSs. These include health management organizations (HMOs), selective contracting arrangements and worker's compensation managed care organizations. The commenter believed that it was consistent with the intent of the proposal to allow the same opportunity for waiver of deductibles and copayments. The commenter noted that these organizations are State regulated in the same way as an ODS.

RESPONSE: The Department agrees that it might be appropriate to expand the entities to which the discount applies. However, the changes requested by the commenter would constitute a substantive change requiring additional notice and public comment. The Department will review the implementation of the procedure and make a determination

about whether the additions requested by the commenter are appropriate at some future date.

COMMENT: One commenter supported the provision permitting insurers to waive the policy copayment and deductible for agreeing to be treated by an insurer's ODS providers. The commenter was concerned about how this provision would interact with the 30 percent copayment for using an out-of-network ASC. The commenter requested that the proposal be modified upon adoption to prohibit an insurer from imposing penalty copayments for using out-of-network facilities.

RESPONSE: The Department does not believe that there is any conflict between the waiver of copays and deductibles for treatment in an ODS that has contracted with the insurer and the penalty copayment for not using an voluntary network. First, as discussed above in response to another comment, an ODS that has contracted with an insurer can provide all forms of treatment, not just that in an ASC. Second, if an insurer had a ODS that provided ASC services that was also approved as a voluntary ASC network, an insured who obtained covered services outside the network would not get the benefit of the waiver deductibles and copayments and would have to pay the penalty deductible. That situation would be no different than that in effect now when an insured gets treatment outside of the other voluntary networks that insurers have.

COMMENT: One commenter suggested that the Department amend the rule upon adoption to clarify what information must be made available to the insured as follows:

“1. Upon receipt of notification of a claim, the insurer **or its vendor** shall make available to the insured information about physicians and facilities in any ODS with which it has a contract. **The insurer shall be deemed to have satisfied this requirement if it provides the insured with the name, telephone number and internet address (if one exists) of any ODS with which it has a contract. The insurer may also, but shall not be required to, provide the insured with a list of individual physicians or facilities that are members of the ODS.**” (additions in boldface).

RESPONSE: The Department does not agree with the commenter’s suggestion for an amendment. The definition of “insurer” in the rule at N.J.A.C. 11:3-4.2 already includes a vendor for the purposes of communicating information to insureds. The procedure for notifying insureds about the availability of ODS providers should be in the insurer’s decision point review plan or in its policy forms, which are reviewed and approved by the Department. The Department does not wish to mandate a specific type of notification at this time. The Department will monitor how the information about ODS providers is disseminated and will consider adding additional requirements if it becomes necessary.

COMMENT: One commenter stated that the proposed amendments waiving deductible and copayments when treatment is obtained through an ODS appears to benefit the insured but the only benefits are to insurers. The commenter stated that insureds do not think about who, what and how their medical treatment and bills will be handled in the event of an accident when they purchase insurance. The commenter contrasted this with the way insureds purchase health insurance when they select a plan that suits their needs and resources. The commenter also stated that insurers are not required to have large

networks of doctors and facilities in their ODS and this creates a potential abuse where the insured could be unable to find a provider. The commenter also questioned why the Department needed to make the proposal when they had already addressed the concerns about fees charged by providers by promulgating a comprehensive fee schedule.

RESPONSE: The Department does not agree with the commenter. The insured does not have to make any advance choices when he or she buys or renews a policy. The choice to waive the deductibles and copayments by treating with a provider who has contracted with the insurer's ODS is made when the insured seeks treatment. If the insured chooses not to go to an ODS provider, he or she can go to any provider but the statutory deductibles and copayments would apply. The Department also does not agree with the commenter about auto insurer ODS networks. These networks are required to be approved by the Department and are typically the same networks of providers as those used in health care. Finally, payments to providers in ODS networks are typically 30 percent less than the fees on the PIP medical fee schedule. There are also hospital networks for which there is no fee schedule. There would be a benefit to the insured in extending the amount of his or her policy benefit and well as helping to put downward pressure on insurance rates.

COMMENT: One commenter stated that the savings to insureds by waiving the deductible and copayment for treatment by a provider in an ODS that has contracted with the insurer is illusory because, in most cases, the deductible and copayment would be met by the initial ambulance bill, hospital and ER treatment where it would not be possible to choose an in-network provider. The commenter stated that if the goal is to help insureds

who cannot afford the deductibles and copayments, the Department should eliminate them altogether.

RESPONSE: The Department does not agree with the commenter. Although there are many cases in which the emergency treatment at the time of the accident would use up the deductibles and copayment, there are many cases where insureds do not seek treatment at the time of the accident but develop symptoms later. The Department is not proposing this amendment out of concern that insureds cannot afford deductibles and copayment but rather to extend policy benefits and thereby give insureds more covered treatment for their claim dollar.

COMMENT: Several commenters believed it was unfair to let insurers waive deductibles and copayments when providers were not allowed to do so, referencing lawsuits filed against certain providers.

RESPONSE: The Department does not agree with the commenters. The Legislature established various deductibles and copayments and gave the Department the ability to impose others. These deductibles and copayments are designed to reduce the cost of the PIP coverage by having insureds be responsible for paying for a portion of their treatment. Providers are not permitted to waive deductibles and copayments because this would defeat the purpose of the deductibles and copayments. However, the imposition of copayments and deductibles, and therefore the ability to waive them, is within the discretion of the Commissioner pursuant to N.J.S.A. 39:6A-4. The Commissioner has determined that waiving deductibles and copayments when an insured gets treatment

within an ODS is likely to result in a bigger cost saving than if the insured paid the deductible and copay.

COMMENT: One commenter requested clarification on whether an insurer could impose penalty copayments on out of network ASCs prior to the establishment of an ASC network. The commenter also asked whether insurers would be permitted to impose penalty copayments on policyholders prior to the next renewal of the policy. The commenter also asked what kind of notification about available networks would be provided to policyholders.

RESPONSE: The Department does not believe that any clarification in the rule is necessary. First, the penalty copayments are imposed on the policyholder, not the ASC. Second, a policyholder will not receive a copayment penalty unless the ASC network has been approved. The insurer will include provisions on how it will advise its insureds about the availability of the ASC network in its decision point review plan. The use of PIP voluntary networks is not required to be in the policy form and thus insurers do not have to phase in use of a voluntary network as policies renew.

COMMENT: One commenter stated that the rule failed to provide a carve out for an insured who is currently receiving medical care from a provider who elects not to join an approved network or is closed out of one. The commenter stated that this fact has the possibility of significantly disrupting the provider/patient relationship and continuity of care.

RESPONSE: The Department does not agree with the commenter. If the commenter is referring to the inclusion of ASCs in the list of permitted voluntary networks, the Department does not believe that anyone has a personal relationship with a surgery center. Moreover, the Department believes that the relationships which develop between providers of medical care and their patients are not impacted by these amendments because an insured may still obtain treatment from a provider who is not within an ODS and would merely have to comply with all applicable deductibles and copayments to do so.

COMMENT: One commenter stated that the proposed amendments were unclear as to whether networks of ASCs would be open to all willing providers and, if not, whether ASCs that were not permitted to join the network would be subject to the copayment penalties.

RESPONSE: N.J.A.C. 11:3-4.8(a) states that PIP voluntary networks must be, “a health maintenance organization licensed pursuant to N.J.S.A. 26:2J-1 et seq.; or approved by the Department as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37 and 11:24A-4.10; or approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6, or is licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 and 11:24B.” The rules for the formation of these networks are outside the scope of this proposal.

COMMENT: One commenter calculated that the deductibles and copayments that would be waived by an insurer for the patient's agreement to be treated by a provider in an ODS amount to \$1,200 for the average insured. The commenter questioned how much more



treatment the patient could receive from the \$1,200 savings. The commenter believes that the insurance companies are the winners by reducing the costs of medical services for which the insured has already paid.

RESPONSE: The Department does not agree with the commenter. In addition to the savings on the deductible and copayment, the insured benefits if each claim dollar can pay for more treatment because of the lower price that the insurer pays to an ODS provider for services. Unlike health insurance, where it is quite rare for an insured to reach the maximum lifetime benefit, PIP coverage has a much lower limit. While most insureds still purchase the \$250,000 PIP coverage, more and more insureds are purchasing lower limits of PIP coverage. If these insureds choose to be treated by providers in the insurer's ODS network, they can get much more treatment than they would otherwise get before reaching the coverage limit.

COMMENT: Several commenters stated that the definition of "ambulatory surgical facility" was not consistent with the definition in the Department of Health and Senior Services' licensing rule for ASCs, N.J.A.C. 8:43A-1.3, because it includes physician-owned operating rooms in an office setting. Another commenter noted the passage of P.L. 2009, c. 24, which defines a surgical practice. The commenter suggested that the Department use the definition in the Department of Health and Senior Service's rule.

RESPONSE: The Department does not agree with the first commenter. The definition of "ambulatory surgical facility" in the proposal came from the Auto Medical Fee Schedule rules at N.J.A.C. 11:3-29. When the Fee Schedule rules were adopted in 2007, the Department responded to a similar comment as follows:

The definition of an “ambulatory surgical facility” (ASC) in N.J.A.C. 11:3-29 comes in part from the rules of the Department of Health and Senior Services, which requires that to be licensed, the facility where surgical cases are performed must be separate and apart from any other facility licensee, such as a hospital. The other part of the definition comes from the definitions of “operating room” and “office” in the rules of the Board of Medical Examiners at N.J.A.C. 13:35-4A.3. In addition, such facilities must be certified by Medicare.

P.L. 2009, c. 24 was passed just as this rule was being proposed. The Department will review the statute and determine if the definition of “ambulatory surgical facility” in this rule and the Medical Fee Schedule rules needs to be amended due to that enactment.

COMMENT: One commenter addressed the amendment to N.J.A.C. 11:3-4.4(f), recodified in the proposal as subsection (g). The commenter thought that it would be clearer to continue to refer to the actual services permitted to be offered through voluntary networks rather than reference N.J.A.C. 11:3-4.8(b). Several commenters believed that insurers would use the new language in N.J.A.C. 11:3-4.4(g) to try to apply the network rule to physicians’ services at ASCs. These commenters stated that the rule should expressly state that services of the treating physician are not included in the ASC networks to be permitted by the adopted amendments to N.J.A.C. 11:3-4.8(b). One commenter suggested that the language be amended upon adoption to read, “services,

equipment or accommodations **provided by** [in] an ambulatory surgical facility.”  
(addition in boldface; deletion in brackets).

RESPONSE: The Department agrees with the commenter in part. The non-emergency services for which an insurer can use a voluntary network are listed in N.J.A.C. 11:3-4.8(b). The amendment to N.J.A.C. 11:3-4.4(f), recodified as subsection (g), simply references N.J.A.C. 11:3-4.8(b), rather than having the same list appear in two places in the rule. The amendments to N.J.A.C. 11:3-4.4(g) do not give insurers the ability to use voluntary networks for any additional services. The Department agrees that some clarification is necessary to specify that voluntary networks may be offered for the provision of benefits for services, equipment or accommodations provided by ASCs, but not for physicians’ services rendered at ASCs. The language change suggested by the commenter more accurately expresses what was intended and the Department is amending the rule upon adoption to so provide.

COMMENT: Several commenters objected to the addition of ASCs to the list of permitted voluntary PIP networks in N.J.A.C. 11:3-4.8 as simple targeting of ASCs for payment reductions. The commenter noted that the recently implemented amendments to the PIP fee schedule reduced ASC fees and questioned whether the amendment was necessary. The commenter asked whether patients in non-network ASCs would be subject to the penalty copayment if few or no ASCs joined an insurer’s network.

RESPONSE: The Department does not agree with the commenters. ASCs are similar to the other types of benefit providers on the list in that the facility does not treat patients. There are benefits other than the amount of the fees paid to the facilities when insurers

have networks. For example, ease in scheduling treatment and rapid payment for services are other benefits. The Department doubts that the situation raised by the commenter where few or no ASCs would be in a network will occur. Furthermore, all network providers for PIP must already be approved by the Department for HMO's or other payors and must meet the standards for those payors, which includes adequate geographical representation.

COMMENT: One commenter stated that the proposed amendment adding ASCs to the list of permitted voluntary networks would have the effect of reducing the reimbursement to ASCs because they will have no choice but to join or face drastic reductions in revenue. The commenter also stated that this effect was contrary to the long-standing State policy of reimbursing medical providers fairly, which is evidenced by the statutory standard for the fee schedule rule at N.J.S.A. 39:6A-4.6. The commenter also stated that it would be irresponsible for the Department to adopt the proposed amendments before determining the social and economic impact of the recently implemented changes to the Medical Fee Schedule rule. The commenter recommended waiting a significant period of time, at least two years before, adopting the proposed changes.

RESPONSE: The Department does not agree with the commenter. Although some ASCs may experience a reduction in per procedure revenue, the Department believes that the benefits provided to insureds who will receive more medical treatment for their claim dollar by going to facilities in a network outweigh any such losses that may be incurred by ASCs. The Department also does not agree that it is necessary to wait to adopt the proposal. As of the date of this adoption, the fee schedule rule has been in effect more

than six months and the Department is not aware of any reduction in the number of ASCs available to insureds.

COMMENT: One commenter stated that requiring insureds to use only those ASCs that are in an insurer's network would restrict an insured's right to have operative procedures by the medical provider of their choice, since not all physicians have privileges in the network ASCs. The commenter stated that this would force the patient to either pay the penalty copayment, have the procedure performed by a different physician or have it done in a hospital. The commenter believed that most patients would choose to have the procedure done by their treating physician in a hospital, which would result in the insurer paying more money for the service than it if were done in an ASC.

RESPONSE: The Department does not agree with the commenter. The amendments do not require insureds to use only those ASCs that are in an insurer's network; however, the failure to use approved ASC networks would incur a 30 percent penalty copayment for the ASC facility fees. The Department also believes that the commenter's assertion that most insureds will choose to have the procedure performed in a hospital and that such will be more costly is speculation. The Department will monitor the implementation of the amendments to determine if changes are necessary.

COMMENT: One commenter stated that there are no safeguards in the rule preventing the formation of inadequate networks and that the proposed regulation could result in the formation of networks that are deficient in the number of facilities, geographic scope,

type of services offered and quality of care. The commenter stated that if no facility in a network offered the particular specialty needed, the patient would be forced to pay a penalty copayment for the service.

RESPONSE: The Department does not agree with the commenter. Any network used by a PIP insurer must already have been credentialed for use by other payors, such as HMOs and worker's compensation carriers. The Department also does not agree with the scenario suggested by the commenter. An ASC simply provides the room for a procedure to be done. In addition, there is always the alternative to have the procedure done in a hospital.

COMMENT: One commenter stated that there is no indication that a 30 percent penalty for going out of network is an appropriate number. The commenter asked if this figure is tied to some cost analysis and stated it unconscionably forces insureds to seek in-network treatment.

RESPONSE: The Department does not agree with the commenter. The amount of the out of network penalty was not amended by the proposal and therefore is outside the scope of this rulemaking. However, the Department based the penalty copayment amount on that used by health care payors such as HMOs.

COMMENT: One commenter opposed the inclusion of ASCs in PIP networks. The commenter stated that provider networks disrupt the continuity of care and, while acknowledging that insureds do not have an ASC of record, an insured may have a referring orthopedist or primary care physician of record.

RESPONSE: As noted above in response to another comment, if the patient's surgeon does not have a relationship with a network ASC, the procedure can be performed in a hospital.

COMMENT: One commenter observed that the fundamental element of networks is the volume for discount fee negotiation. The commenter stated that this did not apply to PIP, especially where the fees for services are established by the fee schedule rule. The commenter requested that the amendments to N.J.A.C. 11:3-4.4 and 4.8 not be adopted.

RESPONSE: The Department does not agree with the commenter. As noted above in response to another comment, any ASC network must also be used by some other payor such as an HMO or a selective contracting arrangement. PIP patients will simply add to the volume of patients that the ASC is already receiving through these other entities.

COMMENT: Another commenter stated that the decision of the Appellate Division *In re Adoption of N.J.A.C. 11:3-29*, 410 N.J. Super. 6 (App. Div.), *certif. den.* 200 N.J. 506 (2009), negates the need for the inclusion of ASCs in insurer's voluntary networks because fees have been established for services performed in ASCs. The commenter also believed that the 30 percent copayment penalty for services in out-of-network ASCs sanctions the reduction of reimbursement rates below the reimbursement levels that are statutorily mandated either by the PIP fee schedule or the usual, reasonable and customary fee for services not on the fee schedule.

RESPONSE: The Department does not agree that the implementation of the medical fee schedule rule subsequent to the Appellate Division decision referenced by the commenter

negates the need for the amendment to permit ASCs to be included in insurers' voluntary networks. The Medical Fee Schedule rules, N.J.A.C. 11:3-29, clearly state that the fees in the schedules are a ceiling, the maximum that an insurer can reimburse a provider for a service. Providers often bill and receive fees lower than those on the fee schedule. Moreover, use of out-of-network ASCs will not result in a reduction of facility fee reimbursement rates below what is "reasonable and prevailing." The 30 percent copayment penalty for using out-of-network ASCs only requires the insured to pay an additional 30 percent of the facility fee "out-of-pocket" to the out-of-network ASC. The charges received by the ASC are not reduced by the application of this penalty copayment.

COMMENT: One commenter stated that surgical services are not the type of service that should be offered by a voluntary network. The commenter believed that the voluntary networks were established to control costs for certain non-emergency ancillary services such as MRIs and durable medical equipment (DME).

RESPONSE: The Department does not agree with the commenter. The ASC network would cover the facility fees for services provided in ASCs. The operating rooms and support services provided in ASCs are exactly the kind of non-personal and non-medical services that are appropriate for a voluntary network.

COMMENT: One commenter stated that the Department was allowing itself to be used as a tool by insurers to drive facilities into networks. The commenter stated that the proposal would allow insurers to waive policy deductibles and copayments to get



treatment from in-network providers at the same time imposing significant penalties for failure to use an approved network.

RESPONSE: The Department does not agree with the commenter that it or its proposal is an insurer tool. The ODS provisions in the amendment allow the insured to receive more treatment for their claim dollar with no reduction in the quality of care. The commenter also does not seem to understand the proposal. The waiver of policy deductibles and copayments is a benefit to the insured, not a reduction in the payment to the provider. The proposed amendment that permits waiving of the insured's policy deductibles and copayments applies to any kind of treatment for which the insurer has an ODS, not just ASC facility fees.

COMMENT: One commenter stated that the proposal authorizing the inclusion of ASCs in voluntary networks would deprive a patient of the benefit of his or her policy because it imposes significant penalties on a patient who chooses to use an out-of-network facility.

RESPONSE: The Department does not agree with the commenter. The use of penalties for out-of-network treatment is universal in health care. Further, N.J.S.A. 39:6A-4 states that the Commissioner may establish the basic benefits of the PIP medical expense benefit and establish excess benefits that may be subject to reasonable copayments. The insured can choose to get treatment in networks that are approved by the Department or pay extra to go out of network.

COMMENT: One commenter expressed concern that the penalty copayment provisions applied across the board without exception because of the uniqueness and urgency of auto-related injury care. The commenter stated that the patient is often in need of immediate medical care and cannot wait until an in-network provider is located. The commenter also stated that the proposed amendments permit an insurer to impose a penalty even if the patient has no choice but to seek medical treatment from an out-of-network provider.

RESPONSE: The Department does not agree with the commenter. ASCs do not provide emergency care. In addition, insurers can provide immediate information to insureds about ASCs in their networks. The Department does not understand how a patient would have no choice to seek treatment from an out-of-network ASC when an ASC only provides the operating room and supplies for the procedure.

COMMENT: Several commenters representing hospitals and ambulatory surgical centers expressed concern that the proposed amendment that would allow insurers to include ASCs in their voluntary networks would create a financial incentive for patients to use ASCs. One commenter noted that patients with certain conditions, such as sleep apnea or a certain body mass index, should not have surgical procedures in ASCs because of the probability of life-threatening complications. The commenter also objected to the provision of the rule that includes physician-owned single operating rooms in the definition of an ASC because they have little oversight by the State. The commenter suggested that the rule be amended upon adoption to include hospitals in the definition of an ASC. Another commenter stated that reducing the number of ambulatory surgeries

performed at hospitals could have a significant negative impact on New Jersey's hospitals. The commenter noted that hospitals in New Jersey were in a fragile economic condition and depended on PIP payments to sustain their state-of-the-art trauma system.

RESPONSE: The Department does not agree with the commenters. The Department's proposed amendments merely provide an economic incentive to use ASCs in an insurer's network. There are economic incentives throughout the health care system that responsible providers must balance against the special needs of the patient. The adopted amendments use the definition of ASC from the Board of Medical Examiners, which refers to the way these entities are licensed. The Department does not believe it can define ASC differently than the way it is defined by the entities that regulate ASCs. The Department also believes that it is speculative to believe that authorization of ASC networks will result in financial losses to hospitals.

COMMENT: One commenter supported the inclusion of ASCs in the voluntary networks permitted for auto insurers. However, the commenter was concerned that providers would refer patients to non-network ASCs without advising them of the 30 percent copayment. The commenter requested that the Department require providers to remind insureds of the copay penalty for going out of network. The commenter also requested that the Department clarify that the penalty copayment cannot be waived, even if the service provided in the ASC is rendered by the treating physician. The commenter believed that without such guidance the impact of the amendment would be very limited.

RESPONSE: The Department notes that it does not regulate providers or ASCs. The best source of information for insureds about the penalty copayments for going out of network

is the insurer's communications with the policyholder. Insurers may also be able to protect against such concerns in the conditions for assignment of benefits that are executed by providers to receive payments from the insurers.

COMMENT: One commenter asked for clarification as to whether services provided in out-of-network ASCs would be subject to the 30 percent copayment penalty.

RESPONSE: If an insurer has an ASC network, pursuant to N.J.A.C. 11:3-4.8 facility fees in out of network ASCs would be subject to the 30 percent penalty copayment.

COMMENT: One commenter asked whether the auto insurers would be exposed to medical malpractice liability by using ODS networks.

RESPONSE: Auto insurers and health payors already use such networks to negotiate fees with providers. The Department is not aware of any such payors being held liable for medical malpractice since they are not practicing medicine.

COMMENT: One commenter stated that the proposal to permit ASC networks in addition to the rest of the onerous "PIP bureaucracy" of precertification requests had caused him to refuse to accept new PIP patients. The commenter suggested that adoption of the rule would result in reduction of physician access for PIP patients.

RESPONSE: The Department understands the frustration of providers who must follow utilization review procedures because a few providers abuse the system with overtreatment and exorbitant billing or against whom insurers apply utilization review standards in an overly restrictive manner. The Department does not regulate providers but

procedures are available for providers and insureds to appeal decisions by insurers or their vendors to deny authorization for treatment or testing as not medically necessary. The Department does not agree with the commenter that the rule as adopted will reduce physician access for PIP patients.

COMMENT: Several commenters were concerned about the insurer's use of ODS networks because providers might be forced into "silent PPOs." A silent PPO is where an auto insurer contracts with a provider network without the knowledge or consent of the providers in the network. When the provider in the network treats a patient injured in an auto accident, the auto insurer reduces the provider's fee to the PPO amount.

RESPONSE: The Department does not agree with the commenter that the proposed amendments create this situation. The "silent PPO" issue has existed for many years and was specifically upheld by the Appellate Division in *Seaview Orthopedics v. National Healthcare Resources, Inc.*, 366 N.J. Super. 501 (App. Div. 2004). In 2004, the Department amended N.J.A.C. 11:3-4.8(e) to include a provision in the voluntary network section of the rules, which states: "Any voluntary network used by an insurer pursuant to this subchapter shall agree to disclose to a participating provider, upon written request, a list of all the clients or other payers that are entitled to a specific rate under the network's contract with the participating provider." It is the obligations of providers to be familiar with the terms of network contracts they sign.

COMMENT: One commenter was concerned about granting insurers the opportunity to establish in-network provider relationships. The commenter stated that this created an

unethical relationship between the treating provider and the insurance companies that indirectly employ them. The commenter believed that it would be possible for physicians to be compelled to under treat or under report patients' injuries due to concerns that they would be ousted from the network. Another commenter stated that there was a conflict of interest for providers hired by the insurer to treat patients.

RESPONSE: The Department does not agree with the commenter. These entities currently exist. Many ODSs already have contracts with auto insurers and are the same entities that provide services to health payors. The auto insurer would have no control over what providers are in an ODS.

COMMENT: One commenter stated that by providing a financial incentive for auto injury patients to be treated by doctors, these patients are steered to physicians who have contractually committed, directly or indirectly, to the insurer. The commenter asserted that it was impossible for such a provider not to compromise his or her loyalty to a patient. The commenter stated that because it was impossible to disassociate the financial aspect of providing medical care from the ethical loyalty due and owing to the patient, the rule should not be adopted.

RESPONSE: The Department does not agree with the commenter. The Department notes that many physicians already contract with networks owned by health payors and many physicians are employed by hospitals. The Department does not believe that there is any more of a conflict of interest for physicians who are employed by these entities than would exist for physicians in networks contracted with auto insurers.

COMMENT: Several commenters stated that the provisions of the proposed rule would destroy the last vestiges of the ASC operation that were left after the Department drastically reduced fees for ASCs when the new fee schedule was implemented. The commenter stated that he was not aware auto insurers are in such financial trouble that they need relief. The commenter believes that the proposal only gives insurers the ability to generate more profits with no relief to the policyholders.

RESPONSE: The Department does not agree with the commenters. While some ASCs' fees were reduced by the implementation of the fee schedule rule, these continuing regulatory advances are appropriate and reasonable to extend insureds' claim dollars and to continue the legitimate PIP cost containment objectives of Automobile Cost Reduction Act (AICRA), P.L. 1998, c. 21. While auto insurers may not be in financial trouble, the costs of PIP coverage continue to rise. For every dollar of PIP premium collected, \$1.18 was paid out in PIP claims to providers. This inadequacy puts upward pressure on rates. The Department's proposals are intended to provide good medical care to insureds while alleviating this upward pressure on the costs of PIP coverage.

COMMENT: Several commenters stated that the adopted amendments to N.J.A.C. 11:3-4.7(c), which prohibit insurers from requiring precertification for new-patient evaluations, make no sense. The commenters stated that most new-patient evaluations are performed shortly after the accident and, as such, would not be subject to precertification. The commenter questioned what would happen if, after the evaluation and management visit, the provider determined that no further care is needed and does not make a precertification request. The commenter suggested that the Department prohibit

precertification for routine follow-up management and evaluation visits in the following scenario:

“For example, an insurer’s prior pre-certification allows for a number of weekly visits for a set number of weeks. For the physician to determine if further care is necessary, he or she must do an examination and evaluation and the regulations expressly provided for same. Such a visit often is not provided for in the prior pre-certification, yet is necessary to determine whether care is required going forward.”

RESPONSE: The Department does not agree with the commenter. First, there are many occasions where a patient has an initial visit to a provider more than 10 days after the accident. The amendment to the rule was prompted by complaints from providers who were refused payment for such visits. The Department agreed with those providers that they cannot submit a precertification request for a patient they have never seen. The Department believes that if a provider makes an evaluation of a patient’s condition and determines that no treatment is necessary, the language of the amendment would not prohibit an insurer from paying for the visit. If some providers abuse the provision, the Department will reexamine it.

As for routine follow-ups in the course of treatment, the provider is expected to make ongoing evaluations of the patient’s progress in the treatment plan during regular visits for treatment. If the provider believes that the patient will need a separate management and evaluation visit, there is no reason why the provider could not request same in a precertification request.



COMMENT: One commenter recommended that the prohibition on insurers requiring precertification for new-patient evaluations should include the tests that are required to make the diagnosis and determine the plan of care.

RESPONSE: The Department does not agree with the commenter. According to the Current Procedural Terminology, a new patient office visit includes taking a problem focused history, making a problem focused examination and medical decision making. The information obtained in the office visit would provide the medical documentation necessary to request precertification of testing.

COMMENT: One commenter objected to the deletion of the requirement that insurers post their Decision Point Review Plans on the Internet and provide the link to the Department. The commenter stated this would make it more difficult for the insured to obtain necessary information and for attorneys to advise their clients.

RESPONSE: The Department understands the concerns of the commenter. However, the rule still requires that an insurer's Decision Point Review Plan include an explanation of how the information about using the Plan will be distributed to policyholders, providers and injured persons. Insurers can certainly make access to information about their plans available on the Internet and the Department encourages insurers to use this means of communication. However, it was difficult for the Department to keep current the list of websites for insurers' Decision Point Review Plans it was required to maintain, given its current resources. Insurers changed vendors or merged with other insurers. In addition, some attorneys representing providers in arbitrations tried to claim that insurers' Decision Point Review Plans were invalid because they were not referenced on the

website and this was never the Department's intention. The Department will monitor this issue and address it in future rulemaking, if necessary.

COMMENT: One commenter requested that the Department amend N.J.A.C. 11:3-4.8(b)3 as follows: "The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, **nerve conduction studies including H-reflex** performed by the treating physician..." (addition in boldface) The commenter attached a response from the Department acknowledging that this change ought to be made.

RESPONSE: The Department acknowledges that in correspondence dated in 2004, the Department agreed that the NCV (nerve conduction velocity) with H-reflex test is performed with the needle EMG and ought to be included in the physician-performed exemptions from the electrodiagnostic testing that can be done by a network found in N.J.A.C. 11:3-4.8(b)3. Unfortunately, this change was not made in the proposal of these rule amendments. The change cannot be made upon adoption, as it would constitute a substantive change requiring additional notice and public comment. The Department intends to include this change in future rulemaking.

COMMENT: One commenter requested that the Department educate policyholders about the advantages of medical expense benefit and encourage them to select the maximum medical coverage amount under their PIP policies. The commenter also requested that the Department explore raising the \$250,000 maximum PIP benefit.

RESPONSE: The commenter's suggestion is outside the scope of this rulemaking. The Legislature has seen fit to permit a number of PIPS medical expense policy limits. The

Department believes that its role is to inform the public of the choices available, which it does through the Auto Insurance Buyer's Guide sent to insureds upon their initially obtaining coverage and upon renewal.

COMMENT: One commenter stated that it was becoming difficult to practice medicine in New Jersey. The commenter cited the recently implemented PIP fee schedule, Medicare fee reductions and taxes on ASC gross revenues as examples of regulatory actions that prevented physicians from making a return on their investments. The commenter stated that every rule adopted favors insurance companies and hospitals in spite of the fact that ASCs are run more efficiently and have higher patient satisfaction than hospitals. The commenter stated his opinion that insurance companies make too much money and should be forced to charge less for their products.

RESPONSE: The Department does not agree with the commenter. As noted above in response to another comment, the premium for PIP coverage does not cover the amount paid to providers for PIP claims. The Department also notes that there is an Excess Profit regulation which requires that insurers return to their policyholders amounts determined to be excess profits.

COMMENT: One commenter, who is a treating physician for several health payors and who performs IMEs for insurers, stated that the effect of the adoption of the proposal would encourage insureds to seek in-network physicians. The commenter believed that to enter into such a network, the physician would be forced to agree to accept fees lower than the fee schedule and to give up appeal rights and ability to arbitrate. While

acknowledging that there is overtreatment, the commenter believed that the use of such networks would primarily benefit insurance companies and not patients.

RESPONSE: The Department does not agree with the commenter. The ODS networks for which insurers would be permitted to waive deductibles and copayments are some of the same networks used by health payors. If providers in these networks are accepting fees below the PIP fee schedule, then they are accepting the same fees to treat patients covered by health insurance. The Department would not permit any network to force providers to give up their rights to appeal and arbitrate treatment decisions.

COMMENT: Several commenters requested an extension of time to submit comments.

RESPONSE: The Department determined that the 60-day period for the submission of comments on the proposal was adequate and therefore declined to extend the comment period.

### **Federal Standards Statement**

A Federal standards analysis is not required because the adopted amendments are not subject to any Federal requirements or standards.

**Full text** of the adoption follows (additions to proposal indicated in boldface with asterisks **\*thus\***; deletions from proposal indicated in brackets with asterisks \*[thus]\*):

11:3-4.4 Deductibles and co-pays

(a) - (c) (No change.)

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

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

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

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

2. (No change from proposal.)

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

11:3-4.8 Voluntary networks

(a) (No change from proposal.)

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

1. – 5. (No change from proposal.)

6. Services, equipment or accommodations \*[in]\* **provided by** an ambulatory surgery facility.

(c) – (e) (No change from proposal.)

#### 11:3-5.4 Dispute resolution organizations

(a) (No change.)

(b) The dispute resolution organization shall develop and maintain a dispute resolution plan approved by the Commissioner that sets forth its procedures and rules. The dispute resolution plan shall be reviewed at least annually and revisions made upon approval by the Commissioner. The plan shall include the following elements:

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

6. The plan shall provide for a procedure whereby a demand for arbitration based on an insurer's denial of a decision point review or precertification request as not medically necessary, as defined in N.J.A.C. 11:3-4.2, may be submitted directly to an MRO for an expedited determination of medical necessity. No DRP will be assigned and no attorney fees may be charged. The administrator shall set a fee for handling such requests in addition to the MRO fee\*. **The plan shall provide that if the**

**expedited MRO review does not resolve the dispute, the claimant/insured may continue with the standard arbitration procedure before a DRP\*; and**

7. (No change from proposal.)

(c) (No change.)