

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

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

Proposed Repeal and New Rules: N.J.A.C. 11:3-4.7 and 4.8

Proposed Amendments: N.J.A.C. 11:3-4.1, 4.2, 4.4, 4.9, 5.2, 5.11, 25.2 and 25.5

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance

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

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2003-290

Submit comments by September 19, 2003 to:

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The agency proposal follows:

Summary

The Department is making changes to N.J.A.C. 11:3-4, Personal Injury Protection, Medical Protocols, that incorporate more than three years of experience with the program and the input of insureds, providers and insurers. In addition, the Department is making changes necessitated by the recent passage of Public Law 2003, c. 89.

The proposed amendments to N.J.A.C. 11:3-4.1 expand the scope of the subchapter to include the emergency personal injury protection provided under the special automobile insurance policy created by P.L. 2003, c. 89. It is likely that most of the benefits provided under the emergency personal injury protection coverage would be exempt from the decision point review and precertification requirements because they were provided in emergency care as defined in the rules. However, emergency personal injury protection coverage also includes all medically necessary treatment of significant brain and spinal cord injuries and treatment of significant disfigurement, which includes non-emergency care. Application of this rule to benefits provided under the emergency personal injury protection coverage will help ensure that the insured gets the maximum amount of benefits available.

The proposed amendments to N.J.A.C. 11:3-4.2 clarify the definitions of "decision point" and "precertification" and add definitions of "decision point review," "insurer," "network" and "emergency personal injury protection coverage."

The proposed amendments to N.J.A.C. 11:3-4.4(d) incorporate provisions from the Department's Bulletin 99-05 concerning when insurers may impose penalty deductibles for failure to follow decision point review requirements and set the maximum deductible amount at 50 percent. The proposed addition of N.J.A.C. 11:3-4.4(f) permits insurers to charge penalty deductibles not to exceed 30 percent for failure to use networks that have been approved in accordance with this rule. The change to a maximum 30 percent deductible reflects the Department's desire to make PIP utilization review requirements similar to those used in health insurance. The Individual Health Coverage Program (IHC), the Small Employer Health Benefits Program (SEH) and the State Health Benefits Plan all use a 30 percent co-payment for out of

network services. Proposed N.J.A.C. 11:3-4.4(g) clarifies that penalty deductibles are to be imposed on what the insurer would otherwise have paid, which may have been reduced by the deductibles and co-payments required by N.J.A.C. 11:3-4.4(a) and (b).

The Department originally adopted N.J.A.C. 11:3-4.7 and 4.8 in 1998 (see 30 N.J.R. 4401(a) . The 1998 adoption permitted insurers to file precertification plans that incorporated the decision point review requirements. In May 1999, the Department issued Bulletin 99-07, which reversed that policy by limiting treatments or testing that could be precertified and making precertification requirements into an optional separately designated section of an insurer's decision point review plan. In December 2000, the Department adopted amendments to N.J.A.C. 11:3-4.7 and 4.8 (see 32 N.J.R. 4005(c)), which made precertification requirements an optional part of the Decision Point Review Plan filed with the Department. However, N.J.A.C. 11:3-4.8 continued to contain separate requirements for precertification, which in some cases were duplicative of those for Decision Point Review.

At this time, the Department is proposing to complete the process of integrating precertification into the Decision Point Review Plan by repealing N.J.A.C. 11:3-4.7 and 4.8 in their entirety. The proposed new rules clarify that insurers must have a decision point review plan that contains procedures for providers to give insurers advance notice of proposed treatment of the identified injuries that appear on the Care Paths and give advance notice of the decision to administer one of the diagnostic tests listed in N.J.A.C. 11:3-4.5(b). Proposed new N.J.A.C. 11:3-4.7(c)2 permits insurers, at their option, to require precertification of specific treatments, diagnoses or test that it has determined are subject to overutilization and that are separate from decision point review requirements.

A chart at the end of the Summary shows how the existing provisions of N.J.A.C. 11:3-4.7 and 4.8 have been reorganized into proposed new N.J.A.C. 11:3-4.7. Proposed new N.J.A.C. 11:3-4.7 also includes some new requirements for decision point review plans. Proposed new N.J.A.C. 11:3-4.7(c)1 requires that insurers identify if they have a vendor to administer their plan and that the vendor must have a physician medical director. Proposed new N.J.A.C. 11:3-4.7(c)3 requires that insurers make the information for providers and insureds about how to use the plan available on a web site, which can be linked to the Department's web page.

Proposed new N.J.A.C. 11:3-4.7(c)4 makes the maximum time for review of decision point and precertification requests three business days. Proposed new N.J.A.C. 11:3-4.7(c)6 incorporates into the rule the requirement that an insurer have an internal appeals process as part of its decision point review plan. This provision originally appeared in Bulletin 99-07.

Proposed new N.J.A.C. 11:3-4.7(e) includes changes in the provisions for independent medical examinations. Insurers will no longer be able to impose penalty deductibles for failure of the insured to attend a scheduled examination. The deductibles are typically imposed on the provider who may have no control over the attendance of the insured at the examination. The proposed new rule does permit insurers to include reasonable procedures in their decision point review plans for denial of reimbursement of benefits where there is repeated, unexcused failure to attend scheduled examinations, so that the insurer can determine if continued treatment or testing is medically necessary. The proposed new rule also requires insurers to notify the treating provider, in addition to the insured and his/her representative, whether the insurer will continue to reimburse for treatment after the examination.

N.J.A.C. 11:3-4.8 is being proposed for repeal. As noted above, a separate section for precertification is no longer necessary. Proposed new N.J.A.C. 11:3-4.8 contains the requirements for insurers that use voluntary networks. The Department has approved the use of networks on a case by case basis in decision point review plans but believes that it is appropriate to establish standards for the use of networks by insurers. The proposed new rule limits the use of voluntary networks to those for certain types of high-cost testing such as Magnetic Resonance Imagery, as well as durable medical equipment and prescription drugs. The proposed new rule requires that insurers notify insureds of the types of benefits for which it has voluntary networks before the policy is issued and before renewal, so that the insured can choose, if so inclined, to seek an insurer that does not have voluntary networks. Upon notification of a claim under the policy, the insurer shall also provide the insured with a list of its approved networks and a directory of providers in the network.

Proposed new N.J.A.C. 11:3-4.8(b) requires that insurers certify that the voluntary networks they want to offer meet the requirements of the rule. Those requirements are similar to those used in selective contracting arrangements by health insurers and include licensure of providers and facilities in the network by the State where applicable, sufficient levels of malpractice insurance and quality assurance procedures. In addition, insurers that want to use networks must provide the Department with a specimen contract between the network and the providers in the network.

In addition, proposed new N.J.A.C. 11:3-4.8(d) addresses the "hidden PPO" issue where the provider is unaware that the network has contracted with other payers for the network rate for the provider's services. Any network certified pursuant to this subchapter must agree to give

providers a list of all its clients or payers that are entitled to specific rate under the network's contract with the provider.

N.J.A.C. 11:3-4.9(a) is being proposed for amendment to give some examples of the restrictions that can be included in the assignment of benefits. This amendment incorporates the existing practice of the Department in approving decision point review plans.

N.J.A.C. 11:3-4.10 is being proposed for repeal. The reports that were required to be filed by insurers were useful in evaluating the implementation of the changes made by AICRA. However, now that the changes have been in effect for a number of years, the reports have limited usefulness. The Department believes that use of complaints and targeted Market Conduct Examinations are more efficient methods of monitoring insurer performance.

In addition to the changes to N.J.A.C. 11:3-4, the Department is making some changes to other rules that deal with PIP. The proposed amendment to N.J.A.C. 11:3-5.2 adds emergency personal injury protection coverage to the definition of "personal injury protection" to reflect creation of the special automobile insurance policy by P. L. 2003, c. 89. Proposed new N.J.A.C. 11:3-5.11(a) sets an initial fee for the determination by a Medical Review Organization (MRO) as part of a PIP arbitration and allows for adjustment based on the changes in the Medical Component of the Consumer Price Index. When this rule was originally adopted, the Department did not adopt its original proposal for an MRO fee in response to comments made on the proposal that the fee was too low. The Department believes that it is appropriate at this time to set a fee so that users of the system can make a consistent calculation of the cost of using an MRO. The proposed fee, \$575.00, is the fee of one of the certified MRO's adjusted for the

inflation in medical costs. The proposed new rule also permits the Department to adjust the fee by Order every two years to reflect changes in medical costs.

The amendment to N.J.A.C. 11:3-5.2 adds emergency personal injury protection coverage to the definition of Personal Injury Protection to reflect creation of the special automobile insurance policy by P. L. 2003, c. 89. N.J.A.C. 11:3-25.5(d) is being proposed for amendment. The Notification by Treating Medical Providers rule predated the reforms made by the Automobile Insurance Cost Reduction Act (AICRA) and requires that providers notify the insurer within 21 days of the commencement of treatment for injuries sustained in automobile accidents. The proposed amendment exempts providers from the penalties for failure to submit the notice required by the rule if they have provided an alternate form of notice by making a decision point review or precertification request in accordance with the insurer's approved decision point review plan.

As the Department has provided a 60-day comment period on this notice of proposal, the notice is excepted from the rulemaking calendar requirements, pursuant to N.J.A.C. 1:30-3.3(a)5.

Summary of Reorganization of N.J.A.C. 11:3-4.7 and 11:3-4.8				
<u>New Cite</u>	<u>Old Cite</u>	<u>New text in proposed amendments</u>	<u>Text in Existing Rule</u>	<u>Similar requirement for pre-cert</u>
11:3-4.4(d)	11:3-4.7(b) for DRP and 11:3-4.8(h) for precert	[Notwithstanding (a) and (b) above, an insurer may offer alternative deductible and co-pay options as part of an approved pre-certification program pursuant to N.J.A.C. 11:3-4.8.] Failure to request decision point review or recertification where required or failure to provide clinically supported findings that support the treatment or test 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:	The plan may provide that failure to notify the insurer as required in the plan; failure to provide medical records; or failure to appear for the physical examination scheduled in accordance with b(2) above shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical goods and non-medical expenses that	Policy forms may include an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with precertification requirements.
11:3-4.4(d)(1)	11:3-4.7(b)(3)	...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	...are incurred after notification to the insurer is required but before authorization for continued treatment or the administration of a test is made by the insurer.	
11:3-4.4(d)(2)	11:3-4.7(b)(3)	No insurer may impose the additional co-payment where the insurer received the required notice but failed to act in accordance with its approved decision point plan to request further information, modify or deny reimbursement of further treatment or tests.	No insurer may impose the additional co-payment where the insurer received the required notice but failed to act in accordance with its approved decision point plan to authorize or deny reimbursement of further treatment or tests.	
11:3-4.7(a)	11:3-4.7(a)	Every insurer shall file for approval a decision point review plan that meets the requirements of this subchapter.	Insurers shall file for approval policy forms that provide a plan for the timely review of treatment of identified injuries at decision points and for the approval of the administration of the diagnostic tests in N.J.A.C. 11:3-4.5(b)	
11:3-4.7(b)	11:3-4.7(d) for DRP and 11:3-4.8(c) for	No decision point or precertification requirements shall apply within 10 days of the insured event or to treatment administered in emergency care.	No decision point requirement shall apply within 10 days of the insured event. This provision should not be construed so as to require	No precertification requirements shall apply within 10 days of the insured event.

	precertification	This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.	reimbursement of tests and treatment that are not medically necessary.	
11:3-4.7(c)	11:3-4.7(b)	A decision point review plan shall include the following information:	The decision point review plan shall meet the following requirements:	
11:3-4.7(c)2	11:3-4.7(c)	Copies of the informational materials described in (d) below and an explanation of how the insurer will distribute the information to policyholders, injured persons and providers at policy renewal and upon notification of claim. An insurer shall make its informational materials available on the World Wide Web and provide the URL and any changes thereto to the Department's webmaster at: <a href="mailto:webmaster@dobi.state.nj.us">webmaster@dobi.state.nj.us</a> .	All decision point review plans, including a pre-certification program filed and approved pursuant to N.J.A.C. 11:3-4.8 shall contain provisions for the disclosure of the procedures in the decision point review plan to injured persons and providers.	
11:3-4.7(c)3	11:3-4.7(b)1i	Procedures for the prompt review, not to exceed three business days, of decision point review/precertification requests by insureds or providers.	The prompt review of the notice and supporting materials submitted by the provider and authorization or denial of reimbursement for further treatment or tests;	
11:3-4.7(c)3	11:3-4.7(b)1iii for DPR and 11:3-4.8(e)1 for precert	Any denial of reimbursement of further treatments or tests shall be based on the determination of a physician. In the case of treatment prescribed by a dentist, the decision shall be by a dentist	Any denial of reimbursement for further treatment or tests shall be based on the determination of a physician.	Any utilization decision to deny reimbursement for further testing or treatment because the treatment or diagnostic tests are not medically necessary, shall be made by a physician. In the case of treatment prescribed or provided by a dentist, the decision shall be by a dentist;
11:3-4.7(c)4	11:3-4.7(b)1ii	Procedures for the scheduling of physical examinations pursuant to (e) below;	The scheduling of a physical examination of the injured person in accordance with (b)2 below where the notice and supporting materials and other medical records if requested, are not sufficient to authorize or deny reimbursement of further treatment or tests	
11:3-4.7(c)5	Bulletin 99-07	An internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement	Decision point review or precertification plans should include an internal appeal or "second look" provision that allows the provider to discuss	

		for a treatment or the administration of a test.	the decision to deny with the physician.	
11:3-4.7(d)	11:3-4.7(c)	The informational materials to inform policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the following information:	All decision point review plans, including a pre-certification program filed and approved pursuant to N.J.A.C. 11:3-4.8 shall contain provisions for the disclosure of the procedures in the decision point review plan to injured persons and providers.	
11:3-4.7(d)1	11:3-4.7(b)1and 11:3-4.8(e)3 for precertification	How to contact the insurer or vendor to submit decision point review/precertification requests including the phone, facsimile numbers or email addresses. The insurer or its vendor shall be available, at a minimum, during normal working hours to respond to decision point review/precertification requests;	The plan shall include procedures for the injured person or his or her designee to provide prior notice to the insurer or its designee together with the appropriate clinically supported findings that additional treatment or the administration of a test in accordance with N.J.A.C. 11:3-4.5(b) is medically necessary, as follows:	The utilization management program shall be available, at a minimum, during normal working hours to respond to authorization requests.
11:3-4.7(d)3	11:3-4.8(f)	A list of the medical procedures, treatments, diagnoses, diagnostic tests, durable medical equipment or other services that require precertification pursuant to N.J.A.C. 11:3-4.7(f), if any.	The insurer shall include precertification requirements in the information about its decision point review plan that will be given to consumers with new and renewal policies and upon notice of a claim. The consumer information shall include at a minimum the items in N.J.A.C. 11:3-4.7(d).	
11:3-4.7(d)4	11:3-4.7(c)iii	An explanation of how the insurer will respond to decision point review and precertification requests, including time frames. The materials should indicate that:	How authorization for treatment and the administration of tests may be obtained.	
11:3-4.7(d)4ii	Bulletin 99-05	If the insurer fails to respond to a request for decision point review or precertification within the timeframes called for in its plan, the treatment or test may proceed until the insurer notifies the provider that reimbursement for the treatment or test is not authorized; and	The materials should affirmatively state that if the insurer does not respond within the stated time-frame, the provider may proceed with the treatment or test. In addition, the plan should provide that if a physical or mental examination is required, treatment may proceed while the exam is being scheduled, and until the	

			results are available.	
11:3-4.7(d)7	11:3-4.7(c)ii	An explanation of the penalty co-payments imposed for the failure to submit decision point review or precertification requests where required in accordance with N.J.A.C. 11:3-4.4(d);	The financial responsibility of the provider for providing treatment or administering tests without authorization from the insurer; and	
11:3-4.7(e)	11:3-4.7(b)2	A physical examination of the injured party as part of a decision point review or precertification shall be conducted as follows:	A physical examination of the injured party as part of a decision point review shall be conducted as follows:	
11:3-4.7(e)1	11:3-4.7(b)2i	The insurer shall notify the injured person or his or her designee that a physical examination is required for reimbursement of further treatment or tests. An insurer shall include reasonable procedures for the notification of the injured person and the treating medical provider where reimbursement of further treatment or testing will be denied for failure to appear at scheduled medical examinations.	The insurer shall notify the injured person or his or her designee that a physical examination is required;	
11:3-4.7(e)2	11:3-4.7(b)2ii	The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice in (e)1 above unless the injured person agrees to extend the time period;	The physical examination shall be scheduled within seven calendar days of receipt of the notice in (b)1 above unless the injured person agrees to extend the time period;	
11:3-4.7(e)3	11:3-4.7(b)2iii	The medical examination shall be conducted by a provider in the same discipline as the treating provider;	The medical examination shall be conducted by a provider in the same discipline as the treating provider;	
11:3-4.7(e)4	11:3-4.7(b)2iv	The medical examination shall be conducted at a location reasonably convenient to the injured person;	The medical examination shall be conducted at a location reasonably convenient to the injured person;	

11:3-4.7(e)5	11:3-4.7(b)2v	The injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before; and	The treating provider or injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided no later than the time of the examination; and	
11:3-4.7(e)6	11:3-4.7(b)2vi	The insurer shall notify the injured person, his or her designee and the treating medical provider whether it will reimburse for further treatment or tests as promptly as possible but in no case later than three days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.	The insurer shall notify the injured person or his or her designee whether reimbursement for further treatment or tests is authorized as promptly as possible but in no case later than three days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.	
11:3-4.7(f)	11:3-4.8(a)	Insurers may include in their decision point review plan a list of specific medical procedures, treatments, diagnoses, diagnostic tests, other services or durable medical equipment that are subject to precertification. The medical procedures, treatments, 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...		Insurers may require precertification of certain specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.
11:3-4.7(g)	11:3-4.7(b)4 for DPR and 11:3-4.8(i) for precertification	In administering decision point review, insurers shall avoid undue interruptions in a course of treatment.	The plan shall avoid undue interruptions in a course of treatment.	Precertification shall avoid undue interruptions in a course of treatment.
11:3-4.7(g)	11:3-4.7(b)5 for DPR and 11:3-4.8(j) for precertification	Insurers are encouraged to provide decision point review plans that permit the treating provider to submit for review a comprehensive treatment plan so as to minimize the need for	Insurers are encouraged to permit a treating provider to submit a comprehensive treatment plan for precertification so as to minimize the need for	

	cation	piecemeal review.	piecemeal review.	
11:3-4.7(h)	11:3-4.8(e)2	An insurer shall not retrospectively deny payment for treatment or testing where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless fraudulent information was submitted by the person receiving treatment or the provider or there was no coverage in effect.		A utilization management decision shall not retrospectively deny payment for treatment provided when prior approval has been obtained, unless the approval was based upon fraudulent information submitted by the person receiving treatment or the provider;

### Social Impact

These proposed new rules, repeals and amendments will have a beneficial social impact by clarifying the requirements of AICRA as it relates to PIP medical expense benefits. The proposed new rules and amendments make it easier for insurers, insureds and providers to understand and comply with the requirements. The new rules will also bring treatment of voluntary networks closer in line with networks in the health insurance context – reducing deductible penalties and assuring that consumers are aware of the presence of a voluntary network and the consequent restrictions on choice of health providers before they purchase insurance.

### Economic Impact

Private passenger automobile insurers currently file decision point review plans with the Department. The proposed new rules and amendments will require that those plans be refiled to conform to the changes in the rules, which will have an economic effect on insurers. The proposed new rules also require that networks used by insurers and their vendors be certified by the Department. The certification process will have an economic impact on insurers. However, the Department believes that certification of networks will ensure that insureds receive the highest quality of care. Finally, the reduction of the maximum penalty co-payment for going out of network has been reduced from 50 to 30 percent. Not all insurers have networks and not all of them used a 50 percent co-payment. However, for those that did, the reduction of the co-payment will increase the payments to providers. Insureds subject to the penalty co-payment will pay correspondingly less for going out of network. As noted in the Summary, the 30 percent co-

payment is commonly used in health insurance and the Department wants utilization review under PIP to mirror that of health insurance as much as possible.

The Department will bear the cost of review and approval of these new policy forms, as required by the Act. Additionally, the Department will bear the continuing costs of monitoring the application of the new policy form standards. These costs will be absorbed within the Department's existing appropriation. The repeal of the reporting requirement will reduce costs for the insurers to prepare the reports and for the Department to analyze them.

#### Federal Standards Statement

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

#### Jobs Impact

The Department does not believe that the proposed new rules, repeals and amendments will have any impact on jobs. However, the Department invites interested persons to submit any data or studies about the jobs impact of these proposed rules with their written comments.

#### Agriculture Industry Impact

The Department does not anticipate any impact from the proposed new rules, repeals and amendments upon agriculture and related industries.

#### Regulatory Flexibility Analysis

These proposed new rules, repeals and amendments impose compliance requirements upon private passenger automobile insurers, some of which may be small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Pursuant to N.J.A.C. 1:30-3.1(f)4, the Department provides the following regulatory flexibility analysis regarding those small businesses upon which the proposed new rules impose compliance requirements. Insurers will be required to refile their decision point review plans to conform them to changes in the proposed new rules and amendments. Insurers that contract with networks for the provision of certain medical services to insureds will have to have the networks certified by the Department. In addition, insurers will have to establish a single address for the filing of demands for arbitration of PIP claims. However, the requirement that insurers file monthly reports on decision point review activity has been repealed. Many insurers, including most small ones contract with a PIP vendor to provide these services and it will be the vendor's responsibility to make the changes required by the proposed new rules and amendments. The insurer may be required to make changes in computer programming and other internal processes.

These rules provide no different compliance standard for small business insurers. All auto insurance policies are required to provide the PIP medical expense benefits as set forth in N.J.S.A. 39:6A-4, 39:6A-3.1 and section 45 of the Act. These rules provide standards intended to ensure that unnecessary costs are reduced in the provision PIP medical benefits while still ensuring that persons injured in automobile accidents get necessary treatment. In order to assure that all PIP coverage provided by auto insurers meets these minimum requirements, no differing compliance requirements for automobile insurers based on business size is appropriate.

### Smart Growth Impact

The proposed new rules, repeals and amendments would have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

**Full text** of the proposed repeals may be found at N.J.A.C. 11:3-4.7, 4.8 and 4.10.

**Full text** of the proposed new rules and amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

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

11:3-4.1 Scope and purpose

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

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

(c) (No change.)

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.

. . .

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

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

...

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

...

**“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.**

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

**“PIP vendor” means a company used by an insurer to administer its decision point review plan.**

“Pre[-]certification” **or “precertification request”** means [a program, described in policy forms in compliance with these rules, by which the medical necessity of certain diagnostic tests, medical treatments and procedures are subject to prior authorization, utilization review and/or case management] **the procedures in an insurer’s approved decision point review plan for the insurer to receive notice and respond to requests for listed specific medical procedures,**

**treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.**

11:3-4.4                      Deductibles and co-pays

(a) – (c)                      (No change.)

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

**4.8.] Failure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment or test 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.**

**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 plan to request further information, modify or deny reimbursement of further treatment or tests.**

(e)                      (No change.)

**(f) An insurer may impose an additional co-payment not to exceed 30 percent of the eligible charge for failure to use an approved network pursuant to N.J.A.C. 11:3-4.8 for medically necessary diagnostic tests as specified in N.J.A.C. 11:3-4.8(b), durable medical equipment and/or prescriptions.**

(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. Such amount may have already been reduced by the application of the co-payments and/or deductibles in (a) and (b) above.

[(f)] (h) (No change in text.)

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 unless it has an approved decision point review plan.

1. Initial decision point review plan filings and amendments to approved plans shall be submitted to the Department at the following address:

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

(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 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, 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. Copies of the informational materials described in (d) below and an explanation of how the insurer will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim. An insurer shall make its informational materials available on the World Wide Web and provide the URL and any changes thereto to the Department's webmaster at: [webmaster@dobi.state.nj.us](mailto:webmaster@dobi.state.nj.us).**

**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 shall be the determination of a physician. In the case of treatment prescribed by a dentist, the decision shall be by a dentist;**

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

**6. An internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or the administration of a test.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before;

6. The insurer shall notify the injured person, his or her designee and the treating medical provider whether it will reimburse for further treatment or tests 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 testing after repeated unexcused failure to attend a schedule 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 requiring precertification. In addition, the insurer may provide that reimbursement for treatment or tests consistent with the agreed plan will be made without review or audit.

(g) An insurer shall not retrospectively deny payment for treatment or testing where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless fraudulent information was submitted by the person receiving treatment 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.

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

- 1. Magnetic Resonance Imagery;**
- 2. Computer Assisted Tomography;**
- 3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3;**
- 4. Durable medical equipment with a cost or monthly rental in excess of \$50.00; or**
- 5. Prescription drugs.**

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

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

**2. Upon request and upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall provide to the injured person a list of 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:**

- 1. A narrative description of the benefits to be offered through the**

network or networks.

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;

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/](http://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](http://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) Any voluntary network certified 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.**

11:3-4.9 Assignment of benefits; public information

(a) Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage. **Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:**

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

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

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

(b) (No change.)

## SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

### 11:3-5.2 Definitions

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

...

"Personal injury protection" or "PIP" means the coverage provided by a policy of automobile insurance pursuant to N.J.S.A. 39:6A-3.1, [or] 39:6A-4 **or the emergency personal injury protection coverage provided by a Special Automobile Insurance Policy pursuant to section**

**45 of P.L. 2003, c. 89.**

...

## 11:3-5.6 Conduct of PIP dispute resolution proceedings

(a) A request for dispute resolution of a PIP dispute may be made by the injured party, the insured, a provider who is an assignee of PIP benefits or the insurer, in accordance with the terms of the policy as approved by the Commissioner. The request for dispute resolution may include a request for review by a medical review organization. The request shall be made to the administrator and copies sent to other parties.

**1. Every insurer shall establish a single address where requests for dispute resolution shall be sent. Insurers shall notify the administrator of the address and any changes thereto. The administrator shall make the list of insurer addresses available to the user community on a web page and any other available means of communication.**

(b) - (e) (No change.)

## 11:3-5.11 Fees

(a) [(Reserved)] **The initial fee for a determination by a Medical Review Organization shall be \$575. 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.**

(b) (No change.)

**SUBCHAPTER 25. PRIVATE PASSENGER AUTOMOBILE INSURANCE: NOTIFICATION BY TREATING HEALTH CARE PROVIDERS**

## 11:3-25.2 Definitions

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

...

"Personal injury protection" or "PIP" means the coverage set forth at N.J.S.A. 39:6A-4 [or] 39:6A-4 **or the emergency personal injury protection coverage provided by a Special Automobile Insurance Policy pursuant to section 45 of P.L. 2003, c. 89.**

...

11:3-25.5 Late notification

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

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

1. (No change.)
2. When the provider is a secondary medical provider as defined in N.J.A.C.

11:3-25.2; [or]

3. When the medical condition of the injured party made it impossible to comply with the notice requirement[.]; **or**

**4. 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 approved in accordance with N.J.A.C. 11:3-4.**