

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF PROPERTY AND CASUALTY

Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests

Requirements for Insurer Internal Appeals Procedures

Adopted Amendments: N.J.A.C. 11:3-4.2 and 4.9

Adopted Repeal and New Rule: N.J.A.C. 11:3-4.7B

Proposed: November 2, 2015, at 47 N.J.R. 2658(a).

Adopted: September 20, 2016, by Richard J. Badolato, Commissioner, Department of Banking and Insurance.

Filed: September 21, 2016, as R.2016 d.140, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17:29A-14.c(4), 17:33B-42, 39:6A-1.2, 39:6A-3.1, 39:6A-4, 39:6A-4.3, 39:6A-5.1, 39:6A-5.2, and 39:6A-19.

Effective Date: October 17, 2016.

Operative Date: April 17, 2017.

Expiration Date: December 3, 2020.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received timely written comments from Allstate New Jersey Insurance Company, NJM Insurance Group, Plymouth Rock Assurance, Property Casualty Insurers Association of America, Insurance Council of New Jersey, New Jersey Hospital Association, Medical Society of New Jersey, IGEA Brain & Spine, Journal Square Surgical Center, Procura Management, Inc., Healthcare Solutions, Dr. Stuart

Podob, Dr. Richard R Ryan, Rivkind Law Firm, Law Offices of Sean T. Hagan LLC, Chasan Leyner & Lamparello, PC, and New Jersey Association of Ambulatory Surgery Centers, Inc.

COMMENT: One commenter objected to the Department's Social Impact statement in which the Department stated that the "amendments will promote the cost efficient provision of quality medical care to persons injured in automobile accidents ... and have a positive social impact on insureds and insurers." The commenter contends that the amendments will benefit insurers to the detriment of insureds and consumers in New Jersey. The commenter contends that these provisions negatively impact insureds and medical providers by reducing the testing and treatment that they are provided and placing more obstacles for obtaining the testing and treatment and payment of bills.

RESPONSE: The Department disagrees. These rules will benefit insureds and providers by requiring that insurers provide a simple and uniform internal appeal process that enables an efficient review of disputes under Personal Injury Protection (PIP) coverage of an automobile insurance policy. The uniform process will also make it easier for providers to make such appeals.

COMMENT: One commenter objected to the Department's Economic Impact statement. The commenter expressed concern with the Department's statement that the rulemaking will result in PIP medical expense savings for the services provided to insureds and thereby exert downward pressure on automobile insurance rates. The commenter believes that this will only happen if the Department demands that insurers lower their rates at the same time. The commenter contends that the purpose of PIP is to provide expedient and proper treatment and coverage to insureds

involved in a motor vehicle accident. The commenter asserts that the rulemaking will only lower costs for PIP for insurers by increasing their profits through the reduction of care and fees, while premiums for PIP coverage will not change.

RESPONSE: The Department disagrees with the commenter. The rulemaking will have a favorable economic impact on insurers and providers by eliminating many costly disputes and arbitration proceedings. Additionally, the new rule and amendments should also reduce inefficiency in billing and payment fraud and enhance competition, all of which should exert downward pressure on private passenger auto insurance rates.

COMMENT: One commenter objected to the Department's Jobs Impact statement. The commenter contends that the Department has not obtained any information or surveyed providers or suppliers (who may stop treating PIP patients) to see if any jobs will be created or lost as a result of this rulemaking. The commenter contends that many doctors already have stopped seeing PIP patients because of the costly and burdensome requirements of pre-certification, providing records repeatedly, independent medical examinations, delays by the insurer's vendors, lower levels of reimbursement, and improper delays of reimbursement by insurers. The commenter believes that if this provision is adopted, more providers and suppliers will stop treating PIP patients and insureds will be stuck with substandard care and long delays.

RESPONSE: The Department notes that it stated in its Jobs Impact statement that it does not anticipate that any jobs will be generated or lost as a result of these rules or amendments. The Department invited commenters to submit any data or studies about the job impact of these rules. The Department notes that the commenter did not submit any data or studies regarding the rules. The Department notes that in response to virtually every notice of proposal to amend the rules

governing PIP, it receives comments asserting that providers will stop treating PIP patients; however, there is no evidence or indications that such assertions have come or will come to fruition.

COMMENT: One commenter expressed concern with the Department's regulatory flexibility analysis that "small businesses" are insurance companies authorized to write private passenger automobile insurance and/or motor bus medical expense coverage. The commenter argued that small businesses are not multi-million/billion dollar insurance companies but rather medical providers and suppliers within the State who are attempting to survive in business. The commenter believes that the Department's rulemaking will impose undue burdens on providers and insureds and little to no burden on insurers. The commenter further contends that insurers will benefit with increased profits due to paying less claims and reduction in overhead.

RESPONSE: The Department stated that to the extent the proposed new rule and amendments apply to small businesses (as that term is defined in N.J.S.A. 52:14B-16 et seq.), they will apply to New Jersey domiciled private passenger automobile insurers and New Jersey resident providers. Also, adding uniformity to the already existing internal appeal rules will benefit providers by reducing their overhead costs and hopefully reducing the need for costly and time-consuming arbitrations.

COMMENT: One commenter suggested the following amendment to the Department's definition of "days" found in N.J.A.C. 11:3-4.2. The commenter stated that after both instances where the word "Sunday" appears that the phrase "any day that businesses are closed due to a travel restriction from a declared state of emergency" should be inserted. The commenter

believes that this will clarify that in the event that travel restrictions have been issued as part of a declared state of emergency, then that day shall not count as the last designated calendar day under the rule.

RESPONSE: The Department does not agree with the commenter that such an addition to the definition of “days” is necessary. All insurers are required to have Catastrophe Response Plans, which are activated either in anticipation of an event, (for example, Department Bulletin 12-12 advising insurers to activate their plans in anticipation of the arrival of Hurricane Sandy), or after the issuance of a Declaration of a State of Emergency. Insurer Catastrophe Response Plans typically include provisions for the relaxation of deadlines when it is difficult or impossible to conduct normal business.

COMMENT: One commenter requested, for transparency purposes, that the Department identify the interested parties that it consulted with for these rules, as well as prior drafts.

RESPONSE: The Department did not keep a record of the interested parties with which it met. However, the Department meets regularly with insurers and organizations representing insurers, providers, and insurance producers, and engaged in a lengthy consultation process as required by Executive Order No. 2 (2010).

COMMENT: One commenter questioned whether all issues subject to appeal can be contained in a single appeal when there are multiple issues, such as medical necessity, coding, usual, customary and reasonable, and penalties. The commenter stated that, although there will only be one appeal level instead of two, currently most insurance insurers do not change their original decision and it is unclear whether the provider would have to file a separate appeal for each and

every issue that the insurer has denied, modified, and/or not paid properly. The commenter contends that the provider should be able to include all appeal issues in a single form appeal.

RESPONSE: The number of appeals that a provider submits will depend on the circumstances of each case. It is possible that a provider could appeal a determination that a service requested in a Decision Point Review or Precertification request was not medically necessary. If the appeal is granted and the service is performed, it is also possible that the provider will thereafter disagree with the explanation of benefits (EOB) generated for the service and appeal that determination. The forms being developed by the Department for appeals will make it easy for providers and insurers to submit and review appeals by identifying the specific issue(s) being appealed.

COMMENT: Several commenters questioned whether there are consequences if an insurer does not respond to an appeal within the specified time frame. The commenter stated that in the previous notice of proposal the insurer would not be able to contest the same issue in arbitration. The commenter requested confirmation if this requirement still exists and if it does not, the basis for it being removed. The commenter stated that current regulations subject providers to losing their assignment of benefits and the ability to go to arbitration if they fail to appeal timely. The commenter believes a similar consequence should be in place for insurers if they fail to respond. Another commenter believes that the previous penalty on insurers who did not respond to appeals was just and fair. He stated that precertification requests not timely responded to are deemed approved, yet if an insurer fails to respond to an appeal it is irrelevant. If a provider fails to appeal, their claim is barred for failure to abide by the plan and exhaust the internal appeals process. The appeal process thus becomes a process used by insurers simply to try to defeat

claims and not as the Department intended – one used in good faith by insurers to try to work out claims and avoid arbitration.

The commenter also stated that the bulk of appeals are not responded to, that decisions are issued by insurers on appeal that simply parrot the original denial – which more often than not are boilerplate denials with a few specifics of the patient – name, age, how many weeks they have been treating. The commenter asserted that process remains one-sided and these “amendments” do nothing more than to approve a standard form rather than an individual form, and put in place an unwieldy process that, in some cases, is more complicated for certain insurers than their current practice.

RESPONSE: The Department does not agree with the commenters. In its previous notice of proposal, the Department did include a penalty provision for insurers that failed to respond timely to appeals. However, upon review of the comments submitted to that notice of proposal, the Department determined that the penalty was not workable and determined to continue the previous procedure, whereby, the matter is handled as part of an arbitration.

The Department believes, and has repeatedly stated, that the internal appeal process is the venue where the issue being appealed should be addressed fully. Although there is no specific provision for it in the rule, at arbitration, the claimant can still object to the defenses raised by an insurer when the insurer can be shown to have failed to respond to the internal appeal. The Dispute Resolution Professional’s decision should specifically address whether such documentation or information should be considered.

COMMENT: One commenter questioned if there are any extensions or means to request a new decision point review/pre-certification as was originally proposed by the Department, and, if not, what was the basis for eliminating it in instances where a provider misses a deadline for time to appeal. The commenter stated that a busy practice may miss a deadline and there should be an ability to request the treatment plan or seek a post-service appeal prior to filing arbitration rather than simply void a valid assignment of benefits and require the patient consumer to proceed with attempting to get the services properly paid.

RESPONSE: The Department does not agree with the commenter that the rule does not permit a provider to submit another decision point review request if an appeal deadline is missed. The rule is silent on any consequences to providers for failure to submit a timely appeal. Therefore, a provider is free to submit another decision point review request when an appeal deadline has been missed.

COMMENT: One commenter stated that although the Department's rules will add some finality to the appeal process, it still allows insurers to raise any other possible defenses and throw in the kitchen sink as is done by defense counsel in arbitration. The commenter contends that the norm is to raise any and all defenses and hope that one might stick. The commenter stated that if the treatment or bill is not going to be properly addressed in the internal appeals, then the insurer should not be able to dispute the treatment and bill for any other reason than fraud.

RESPONSE: The Department believes, and has stated, that the internal appeal process is the venue where the issue being appealed by the provider should be addressed fully. Although there is no specific provision for it in the rule, at arbitration, both parties can object to additional documentation and information being produced that was available at the time of the internal

appeal but not submitted. The Dispute Resolution Professional should specifically address whether such documentation or information should be considered in his or her decision.

COMMENT: One commenter requested confirmation from the Department that in accordance with N.J.A.C. 11:3-4.7B(a), DPR Plans may also contain additional requirements to assist insurers in obtaining information needed to review and process appeals efficiently as long as they are not in conflict with the Department's rule. The commenter stated that such requirements include the filing of an appeal within 180 days of an adverse decision and at least 45 days prior to initiating arbitration or litigation and submission of a fully completed appeals form with all substantiating documentation to a designated fax number or e-mail address.

The commenter recommended the following amendment:

The internal appeal procedure in an insurer's Decision Point Review Plan (DPR Plan) shall meet the requirements in this section **and may include additional items that are not in direct conflict with these requirements.**

RESPONSE: The Department does not agree with the commenter that the additional language is necessary. The language of the rule already states at N.J.A.C. 11:3-4.7B(a) that the internal appeal procedure shall meet the requirements of this rule, which permits insurers to include other provisions in their internal appeal procedure that do not conflict with the requirements of this rule.

COMMENT: Several commenters suggested amendments to N.J.A.C. 11:3-4.7B(b), which requires that insurers shall only require a one-level appeal procedure for each issue before arbitration.

One commenter stated that he interprets the rule to require that if an insurer initially denies surgery as medically unnecessary but authorizes it on a pre-service internal appeal based on new information and the provider later disagrees about the amount paid, the provider would be required to submit a post-service appeal on the amount of payment before filing for arbitration or litigation on the payment amount. The commenter recommended the following in order to clarify this provision (additions in bold; deletions in brackets):

N.J.A.C. 11:3-4.7B(b) Insurers shall only require a one-level **pre-service and a one-level post-service** appeal procedure for each appealed issue before [arbitration] **initiating alternate dispute resolution**. That is, each issue shall only be required to receive one internal appeal review by the insurer prior to **initiating alternate dispute resolution** [arbitration]. A[n] **post-service** appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than a[n] **post-service** appeal of what the insurer should reimburse the provider for that same service. **Furthermore, a pre-service appeal on the issue of medical necessity is a different issue from a post-service appeal on the issue of medical necessity.**

RESPONSE: The commenter's interpretation of the rule is correct, but the Department does not believe that the suggested changes are necessary as the rule text is clear as written.

COMMENT: A commenter suggested the following amendment to N.J.A.C. 11:3-4.7B(b) (additions in bold):

After the words "appeal procedure," insert **"in accordance with the insurer's DPR Plan and the requirements of this regulation."** This language can be a benefit to all parties, ensuring only sufficient and relevant documents trigger the appeal process.

The commenter also suggested that for the sake of consistency the word "arbitration" or other language meaning legal proceedings in subsequent sections should be deleted and replaced by "initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5, or any other legal proceeding." The commenter contends that this language is an important clarification, since the terms arbitration, alternate dispute resolution, and filing in Superior Court are utilized without consistency throughout the Department's rules. Additionally, the commenter stated that this could be narrowly construed to mean that if arbitration or any other legal proceedings are filed in another state, then there is no requirement to complete the internal appeals process.

RESPONSE: The Department notes that the phrase "dispute resolution" is used throughout N.J.A.C. 11:3-5. The Department agrees with the commenter's suggested deletion of the term "arbitration" and the suggested language that makes the rule internally consistent and will make the changes upon adoption.

COMMENT: One commenter recommends that the Department clarify N.J.A.C. 11:3-4.7B(b) to avoid the filing of a post-service appeal of a decision point/pre-certification denial that had been appealed by way of a pre-service appeal. For example, a provider submits a request for a proposed treatment that is denied by the insurer. The provider submits a pre-service appeal that is also denied. The service is performed and the provider submits the bill to the insurer for payment. The insurer sends an EOB that denies reimbursement based on the prior medical necessity denial. The present language of the regulation may suggest to the provider that a post-service appeal may be filed challenging what the insurer should reimburse. The commenter stated that this would create administrative difficulties for insurers to reply to such appeals. The commenter suggested that the following change would eliminate any confusion (addition in bold):

(b) Insurers shall only require a one-level appeal procedure for each appealed issue before arbitration. That is, each issue shall only be required to receive one internal appeal review by the insurer prior to arbitration. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than an appeal of what the insurer should reimburse the provider **for a service that the insurer has approved as medically necessary.**

RESPONSE: The Department agrees with the example provided by the commenter, but does not agree that additional language needs to be added to the rule. Insurers are permitted to file language in accordance with N.J.A.C. 11:3-4.9(b) that requires providers who are assigned

benefits by the insured to complete an internal appeal prior to requesting alternate dispute resolution pursuant to N.J.A.C. 11:3-5. In that policy language, an insurer may also require that appeals of denials of Decision Point Review or Precertification requests be made as pre-service appeals. If such appeal was denied, the provider could request alternate dispute resolution on that issue but would not be permitted to make a post-service appeal of medical necessity since, in accordance with the one-level appeal limit, the issue of medical necessity had already been appealed.

COMMENT: One commenter sought clarification from the Department on the intent of N.J.A.C. 11:3-4.7B(b). The commenter stated that their understanding is that a reversal of a post-service appeal on the grounds of medical necessity does not allow for the direct filing of arbitration or any other legal proceedings where the amount paid remains in dispute; instead a second post-service appeal would be required in this circumstance if not already addressed.

RESPONSE: The commenter's understanding of the rule is correct. As noted above in response to another comment, insurers may file policy language mandating that medical necessity appeals of the denial of DPR and Precertification requests be made as pre-service appeals.

COMMENT: Several commenters expressed concern with N.J.A.C. 11:3-4.7B(d), which requires that all appeals shall be filed using the form established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). One commenter requested that the appeal forms established by the Department be posted for review and comment by interested parties before adoption of the form, thereby allowing parties the opportunity to provide input into its form and substance.

A second commenter questioned why it is not part of the notice of proposal. The commenter stated that without seeing/reviewing the form, it is unclear whether it will be harmful to the parties, specifically, consumers and providers. The standard form should be made available to the public to review and comment upon prior to being adopted.

RESPONSE: It is the Department's intention to provide an opportunity for interested parties to review and provide feedback on the appeal form prior to the adoption of the rule. The appeal form is not part of the notice of proposal because N.J.A.C. 11:3-4.7(d) permits the Commissioner by Order to require the use of uniform forms. This is preferable to including the form in the rule because it is easier to update the form when necessary if it is implemented by Order.

COMMENT: One commenter wanted to address the information to be contained in an appeal form. The commenter recommended the use of two appeal forms, one for pre-service appeals and a separate one for post-service appeals. The commenter stated that the two types of appeals follow different paths due to the varying time frames and requirements involved with each. The commenter stated that for either type of appeal, it is critical that the basis for the appeal be clearly identified on any form proposed. When a provider does not clearly identify the reasons for the appeal, it is time consuming to determine what issues need to be addressed and evaluated and, as a result, resolution may not occur, thus prompting the filing of unnecessary litigation. The commenter suggested for pre-service appeals that the Department require submission of the original underlying Attending Provider Treatment Form marked "Pre-Service Appeal," and not a separate Pre-Service Appeals form. This will support an efficient and meaningful appeals process and ensure that providers will not have to provide the same information twice.

The commenter attached a copy of its PIP Post-Service Appeals form that was approved by the Department as part of its DPR Plan for reference. The commenter stated that it solicits information needed to gain a clear understanding of the basis for the appeal. At a minimum the commenter recommended that the following items be included in the Department's form for Post-Service Appeals:

- Assignment of Benefits (Yes or No answers and date signed);
- Attorney (if applicable);
- Reason (or Basis) for Appeal;
 - Application of Penalty (30% Out-of Network) and/or 50% penalty for failure to pre-certify treatment);
 - Usual, Customary and Reasonable reduction;
 - Incorrect Application of Fee Schedule (specify below);
 - Coding dispute (e.g. denied as incorrect, denied as inclusive, reduced due to multiple procedures reduction rules, denied as unbundled, etc.);
 - Contractual dispute;
 - Denial of Services based on medical necessity (Peer Review, IME);
 - Termination of Benefits;
 - Overdue Payment;
 - Exhaustion of Policy Limit;
 - Denial of Coverage
 - Other (Specify);
- CPT codes itemized by Date(s) of Service;
- Amount in Dispute;

- Bill ID/EOB# (if applicable).

RESPONSE: The Department thanks the commenter for the suggestions and will consider them in developing the appeal form.

COMMENT: One commenter objected to the definition of “pre-service appeals” in N.J.A.C. 11:3-4.7B(e). The commenter stated that the problem is in the definition “appeals of decision point review and/or precertification denials or modifications **prior to the performance or issuance** of the requested medical procedure ...” The commenter stated that the definition seems to turn on the date of the denial or modification not the date of the request. The commenter provided what she stated was a common occurrence: a provider submits a Decision Point Review request for four weeks of treatment. The insurer does not respond timely to the request and by the time the insurer issues a denial of the request, four of the requested services have already been performed and four have not. In the above, four dates of service would not fit within the definition of pre-service appeal as they had already been performed. The remainder would fit the definition. Thus, a provider would have two different appeals to do regarding the same denial as undoubtedly the form would require the appeal to be specified as either “pre-service” or “post-service.” The commenter believes that under the law, those first four days are “deemed approved.” Yet, the provider would first have to make a post-service appeal for those four dates as being denied for medical necessity and then another post-service appeal when the bill is not paid, and a pre-service appeal for the remainder and a separate bill appeal when that is unpaid. The commenter contends that the system is made even more complicated as under the current practice, since a provider would appeal the entire denial then to do one appeal when all the bills are unpaid.

The commenter contends that they call this practice “bill appeals.” Most of the current plans require a provider to appeal precertification denials and then lump a second tier of everything that is not related to a precertification request as the “bill appeal.” There are exceptions with two tier appeals, but this is generally the norm.

The commenter stated that if the desire is to simplify the process, then the definition needs to conform to how the process actually works. Providers should be required to do one appeal of a precertification/DPR denial or modification within the time period allotted, whenever that denial or modification comes. This first tier should simply be referred to as a “precertification/DPR appeal.”

RESPONSE: The Department does not agree with the commenter. In the example provided, the provider would appeal the medical necessity denial of the treatments that have not yet been performed. The provider would submit a bill for the treatments deemed approved by the failure of the insurer to respond timely to the DPR request and any treatments performed upon a successful appeal of the medical necessity denial. If, upon receipt of an EOB for those services, the provider disagrees with the amount paid for the services for whatever reason, the provider can submit a post-service appeal. The Department does not believe that this procedure is any different than what happens in internal appeals now.

COMMENT: Two commenters stated that in regards to N.J.A.C. 11:3-4.7B(e)1, they are concerned that the listed services do not capture all the services that are currently subject to internal appeals. One commenter recommended adding “prescription drugs and compound medication” to the list (the commenter noted that any modification to this section would also require a similar change to subsection (b)).

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-7B(e)1 already refers to “other service,” which would include the items mentioned by the commenter.

COMMENT: Two commenters suggested that the Department add the following language to N.J.A.C. 11:3-4.7B(f) after the words “requested services:”

and shall not contain information that is identical to the initial material submitted in support of the request for treatment or services. A pre-service appeal shall neither be a prerequisite for, nor take the place of, post-service appeals, and is not required if no new information and/or documentation is available.

One of the commenters believes that this language will assist in the expeditious processing of pre-service appeals by requiring that only new information and/or documentation be submitted. It will also eliminate the need for a provider to submit a pre-service appeal when no new information is available, while ensuring that providers do not circumvent the process by failing to file post-service appeals before initiating arbitration or any other legal proceeding.

RESPONSE: The Department does not agree that the rule should be changed to include the suggested language. An insurer should be able to determine that no new information is being provided with the appeal and deny it on that basis.

COMMENT: One commenter questioned the Department’s basis for extending the deadlines from five days to 30 days for pre-service appeals. The commenter contends that health insurance plans allow for 90 days by statute.

RESPONSE: The Department received many comments on the original notice of proposal that a five-day deadline for pre-service appeals was too short. However, with pre-service appeals, patients are waiting for treatment and the time period should not be too long. The Department notes that there is an expedited appeal process for denial of treatment in health insurance.

COMMENT: Several commenters stated that a five-business-day deadline for the submission of a pre-service appeal is not realistic for specialists and doctors. One of the commenters stated that the person who will be filing the appeal may be out of the office when the request is received. Plus, it takes time to review the denial and patients' charts to do the appeal properly. One of the commenters suggested a 30-day appeal process.

RESPONSE: The commenters have misunderstood the change. The five-day appeal deadline is proposed to be deleted and replaced with a 30-day deadline for filing pre-service appeals.

COMMENT: Several commenters expressed concern with N.J.A.C. 11:3-4.7B(g), which states that, "A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court."

One commenter requested that the Department delete the reference to "Superior Court" in favor of a generic court or simply "litigation" in order to capture all the various avenues that are available to providers.

Additionally, the commenter stated that in order to maximize the efficiency of the internal appeal procedure, they recommended adding the following provision. First, include language to prohibit raising issues in arbitration or litigation not previously reviewed during an internal appeal. The commenter also suggested including language that would limit the record

for any action beyond internal appeals to documentation considered during the internal appeal barring exceptional circumstances. The commenter believes that this requirement would ensure that an insurer has access to all available supporting documentation in order to get the full benefit of the appeal procedure. The commenter stated that language should be added to require an appellant to explain the basis of the appeal to ensure a proper review of the appeal. The commenter contends that it should not simply be that the appellant disagrees with the decision but there must be a basis for appeal and an insurer should have the benefit of knowing what that basis is.

RESPONSE: The Department does not agree that the term “Superior Court” is inappropriate in this context. Litigation involving PIP alternate dispute resolution decisions are typically filed in the Law or Chancery Division of Superior Court. Adding the language suggested by the commenter regarding a prohibition on raising issues in an arbitration because they were not raised in the internal appeal and limiting the record to documentation considered in the internal appeal would be a substantial change requiring additional notice and comment. The Department does not believe that such a change is necessary and notes that it specifically removed similar language from the initial notice of proposal of this rule. The Department agrees that the internal appeal process is the primary forum where disputes about the medical necessity of treatment and billing disputes should be addressed. The purpose of this rulemaking is to provide a uniform, simple-to-use and rapid procedure for appealing insurer decisions. The lengthy, expensive arbitration process should be available to handle complex disputes. Consistent with the foregoing principles, the Department believes that all the relevant information about a dispute should be produced as part of the internal appeal process and only under extraordinary circumstances should additional information be presented as part of the arbitration. However,

the Department believes that the arbitration process itself is the best place for such determinations to be made. Claimants and respondents should object to the submission of information additional to that contained in the record of the internal appeal and absent extraordinary circumstances, the DRP should not consider such information.

COMMENT: One commenter contends that there is no statutory basis in PIP as there is in health care appeal system for the Department's proposed administrative appeals. Additionally, the post-service appeal submission deadline of 45 days is not consistent with the health care appeal system.

RESPONSE: The Department does not agree with the commenter. N.J.S.A. 39:6A-4a gives the Department broad authority over the provision of PIP benefits. The Department notes that the Medical Protocols rules, N.J.A.C. 11:3-4, have required that insurers have an internal appeal process since 2003. The deadline and procedures applicable to health care appeals do not apply to medical treatment under the PIP coverage of an auto insurance policy.

COMMENT: One commenter stated that the proposed regulation is effectively changing the statutory time limitation for filing an arbitration/suit by requiring an internal appeal instead of the two-year statute of limitations.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:4-4.7(b), which permits insurers to require that providers utilize the insurer's internal appeal process prior to filing for alternate dispute resolution, does not change the statute of limitations for filing an action in court. The Department addressed this issue in Bulletin 10-30 as follows:

In N.J.A.C. 11:3-4.9(a)1, the Department permits insurers, as part of an insureds' assignments of benefits to providers, to require the providers to comply with all requirements of the Decision Point Review plans. Moreover, N.J.A.C. 11:3-4.7(c)6 requires insurers' Decision Point Review plans to contain an internal appeals process and such plans may require that the internal appeals process be exhausted prior to the initiation of PIP arbitration. These limited restrictions on the assignment of benefits do not deny payment of a claim or prohibit a provider from accessing the statutorily mandated external dispute resolution process. They merely establish a prerequisite for doing so. It is only reasonable and logical for insurers to require that, before using the expensive and lengthy external dispute resolution process, an insured or a provider under assignment should first utilize the insurer's internal appeals process.

COMMENT: One commenter contends that there is confusion in the notice of proposal's language between pre-service and post-service appeals. The commenter asked in circumstances where the pre-certification request is denied for services that are nevertheless performed whether this a pre-service appeal or a post-service appeal. The commenter questioned if a patient can have services performed regardless of a denial or modification of a treatment plan and only have the provider submit a post-service appeal 45 days prior to filing arbitration. It appears to be the

case as the language of the notice of proposal speaks to when the services are performed as opposed to when the denial is made.

RESPONSE: The Department does not agree that the rule is confusing. Rather, it provides the basic framework within which insurers may use the tools at their disposal. As noted above in response to a previous comment, insurers are permitted to file language in accordance with N.J.A.C. 11:3-4.9(b) that requires providers who are assigned benefits by the insured to complete an internal appeal prior to requesting alternate dispute resolution pursuant to N.J.A.C. 11:3-5. As part of such policy language, which would also be incorporated in the insurer's Decision Point Review plan, an insurer may require that appeals of denials of Decision Point Review or Precertification requests be made as pre-service appeals, namely before the treatment is rendered. If such appeal was denied, the provider could request alternate dispute resolution on that issue either before or after treatment is rendered, but the provider would not be permitted or required to make a second post-service appeal of medical necessity because, in accordance with the one-level appeal limit, the issue of medical necessity had already been appealed.

A provider could also make a post-service appeal on the basis of medical necessity for treatment that was not subject to Decision Point Review or Precertification or that did require such utilization review but the provider failed to obtain such review, in which case, if determined to be medically necessary either through the internal appeal, alternative dispute resolution process, or litigation, the payment for such service would be subject to the 50 percent co-payment penalty provided in N.J.A.C. 11:3-4.4(e).

COMMENT: One commenter suggested adding language to N.J.A.C. 11:3-4.7B(g) that limits a post-service appeal submission to 30 days after the decision is made by the insurer. The

commenter stated that often one or more post-service decisions are made on an individual claimant's case and years pass without any notice of a further dispute with the decision, then the claimant's attorney files numerous post-service appeals on any number of decisions, which significantly raises the costs of providing auto insurance in New Jersey. The commenter stated that their suggested amendment would provide finality on a given decision while still allowing for the dispute of the decision by initiating alternative dispute resolution or filing an action in Superior Court.

RESPONSE: The commenter's suggestion would be a substantive change requiring additional notice and public comment. The Department will monitor post-service appeals filed under the new rule. If such appeals are being filed years after the decision on the claim is made, then the Department will consider amending the rule to address this issue.

COMMENT: One commenter suggested amendments to N.J.A.C. 11:3-4.7B(g). The commenter recommended that the following language be added after the word "submitted" to state "no more than 180 days after the receipt of a denial or modification, and." The commenter stated that this language is suggested since the only time constraint on filing a post-service appeal is that it must be filed 45 days prior to initiating alternate dispute resolution. The commenter contends that it is appropriate to require the post-service appeal be filed within a certain period of time after receipt of a denial or modification. The commenter believes that the current requirement could lead to a situation where a large number of appeals are held and filed at the same time, thus overloading the system and putting undue stress upon insurers to issue all decisions within 30 days.

RESPONSE: The commenter's suggestion would be a substantial change upon adoption requiring additional notice and public comment. The Department does not believe that any one provider's appeals would overload the insurer's system as suggested by the commenter, but as noted above in response to a previous comment, the Department will monitor the implementation of the adopted amendments and new rule and consider further amendments, if necessary.

COMMENT: Two commenters suggested amendments to N.J.A.C. 11:3-4.7B(h), which states that decisions on pre-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation.

These commenters suggested new paragraphs 1 and 2 to N.J.A.C. 11:3-4.7B(h), which would read as follows:

1. If a pre-service appeal is denied and treatment is performed, then initiation of legal proceedings is only allowed 45 days after the filing of a post-service appeal.
2. Legal proceedings regarding a pre-service appeal are only allowed if services have not been rendered.

One of the commenters stated that these additions clarify that legal proceedings cannot be used for a pre-service appeal if a provider decided to provide that treatment after receiving a pre-service decision. In addition, a pre-service appeal should not be viewed as either a prerequisite or replacement for post-service appeals.

RESPONSE: The Department does not agree with the commenter. As noted above in response to a previous comment, the adoption provides the basic framework within which insurers may

use the utilization review tools at their disposal. Insurers are permitted to file language in accordance with N.J.A.C. 11:3-4.9(b) that requires providers who are assigned benefits by the insured to complete an internal appeal prior to requesting alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

As part of such policy language, which would also be incorporated in the insurer's Decision Point Review plan, an insurer may require that appeals of denials of Decision Point Review or Precertification requests be made as pre-service appeals. If such appeal was denied, the provider could request alternate dispute resolution on that issue, but would not be permitted or required to make a post-service appeal of medical necessity since, in accordance with the one-level appeal limit, the issue of medical necessity had already been appealed.

COMMENT: Two commenters suggested amendments to N.J.A.C. 11:3-4.7B(j), which states that nothing in this section shall be construed so as to require reimbursement of services that are not medically necessary or to prevent the application of the penalty co-payments in N.J.A.C. 11:3-4.4(e). The commenters stated that for the sake of consistency with the statutory language, they recommend replacing the words "the penalty" with the word "additional" and add to the citation of the subsection so that it reads N.J.A.C. 11:3-4.4(e), (f) and (g).

RESPONSE: The Department does not agree that the words "the penalty" should be replaced with "additional" in N.J.A.C. 11:3-4.7B(j). The referenced co-payments are properly referred to as "penalty" co-payments because they are imposed when the insured or a provider fails to follow a requirement imposed by the rule. The other co-payments in this section, N.J.A.C. 11:3-4.4(a) and (b) are cost-sharing co-payments required by statute. The Department agrees with the

commenter that N.J.A.C. 11:3-4.7B(j) should include N.J.A.C. 11:3-4.4(f) and (g) in addition to N.J.A.C. 11:3-4.4(e) to reference all the types of penalty co-payments.

COMMENT: Two commenters recommended amendments to N.J.A.C. 11:3-4.7B(j). They suggested amending this provision to read as follows: “As a condition precedent to initiating alternative dispute resolution pursuant to N.J.A.C. 11:3-5, or any other legal proceedings, a provider who has accepted an assignment of benefits or any eligible insured person, shall comply with this internal appeals regulation.”

RESPONSE: The commenter’s suggestion would be a change upon adoption requiring additional notice and public comment. The Department does not believe that the change is necessary, since pursuant to N.J.A.C. 11:3-4.9(b), insurers may file policy language requiring that providers who are assigned benefits by an insured or have a power of attorney from an insured make an internal appeal pursuant to N.J.A.C. 11:3-4.7B prior to making a request for alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

COMMENT: One commenter expressed concern about the rules being clear that insurers must only require a one-level appeal. The commenter stated that there is no express requirement that providers must likewise file an internal appeal before demanding arbitration or filing suit. The commenter suggested that a directive for providers should be added to the proposed rule, so that there is no question of the Department’s intent for a uniform rule to apply in all cases.

RESPONSE: The Department does not agree that the rule is not clear that only a one-level appeal is permitted. However, all insurer internal appeal procedures must be approved as part of the Decision Point Review plans, which will enable the Department to ensure compliance with

the rule. The commenter is correct that there is no express requirement in the rule that providers must file an internal appeal prior to demanding alternate dispute resolution pursuant to N.J.A.C. 11:3-5. However, pursuant to N.J.A.C. 11:3-4.9(b), insurers are permitted to file policy language requiring that providers who are assigned benefits by insured or have a power of attorney from an insured make an internal appeal pursuant to N.J.A.C. 11:3-4.7B prior to making a request for alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

COMMENT: One commenter questioned the benefit of a mandatory pre-service appeal. The commenter stated that in the large majority of claims, the parties simply disagree on the requested course of treatment and there is no new information for the provider to give the insurer to re-consider. To mandate an appeal in this instance would be to generate unnecessary work for both providers and insurers. The commenter contends that in the large majority of claims, the claimant proceeds with treatment despite the denial of the pre-certification by the insurer. There would be no benefit to mandate a pre-service appeal when the intent is to treat anyway. The commenter requested that the Department clarify that the denial of a pre-service appeal cannot qualify for arbitration where the patient is going to treat and present a bill anyway. To do so would potentially allow for two arbitrations and the potential to collect attorney fees twice on the same issue.

The commenter believes that the only time a pre-service appeal would be appropriate is if there is new information for an insurer to consider and treatment has not occurred. The only time that a pre-service appeal can serve as a condition precedent to demanding arbitration is where the treatment does not take place and will not take place before the arbitration. If the treatment occurs, then a post-service appeal must be required before demanding arbitration in

order to give the insurer the opportunity for meaningful review of its decision. The commenter contends that the insurer should accept the service as medically necessary upon review of the appeal, but if a dispute remains as to the amount of payment, a second appeal should be required before permitting a demand for arbitration.

Finally, the commenter contends that a meaningful review can only be accomplished where the claimant submits all documentation that they intend to rely upon at the time of arbitration, including proofs of customary and reasonable charge.

RESPONSE: The Department does not agree with the commenter that there is no benefit in pre-service appeals of medical necessity. The whole purpose of the Decision Point Review and Precertification request process is to give insurers the opportunity to review treatment requests before they are performed. Since the rule was adopted in 1999, it has required that the provider demonstrate that treatment or testing is medically necessary by the use of clinically supported findings. The definition of “clinically supported” states that the provider, “prior to selecting, ordering or the administration of a test,” has examined the patient and recorded his or her findings in the medical record. The pre-service appeal process is part of the DRP/precertification process.

As noted above in response to a previous comment, the rule does not mandate a pre-service appeal of a denial or modification of a DPR or precertification request. The rule permits insurers to make pre-service appeals available to providers, or if the insurer chooses, to make such pre-service appeals mandatory as part of their policy language, which would also be incorporated in the insurer’s Decision Point Review plan. An insurer may require that appeals of denials of Decision Point Review or Precertification requests be made as pre-service appeals or not. If such appeal was denied, the provider could request alternate dispute resolution on that

issue but would not be permitted or required to make a post-service appeal of medical necessity since, in accordance with the one-level appeal limit, the issue of medical necessity had already been appealed. Insurers could require that any new issue raised post-service, such as amount of reimbursement, must be submitted to the internal appeal process before initiating alternate dispute resolution.

The Department agrees that the internal appeal process is the primary forum where disputes about the medical necessity of treatment and billing disputes should be addressed. The purpose of this rulemaking is to provide a uniform, simple-to-use and rapid procedure for appealing insurer decisions. The lengthy, expensive arbitration process should be available to handle more complex disputes. Consistent with the foregoing principles, the Department believes that all the relevant information about a dispute should be produced as part of the internal appeal process and only under extraordinary circumstances should additional information be presented as part of the arbitration. However, the Department believes that the arbitration process itself is the best place for such determinations to be made. Claimants and respondents should object to the submission of information additional to that contained in the record of the internal appeal and absent extraordinary circumstances, the DRP should not admit such information.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7B requires that any supporting documentation for a pre- or post-service appeal be filed along with the original appeal. Currently, once an alternate dispute resolution is filed, the claimant may continue to submit additional documentation on a service appeal, including documentation that was not provided with original appeal.

The commenter recommended that once an appeal has been decided, and an alternate dispute resolution is filed, no new supporting documentation shall be submitted to support the services-level appeal. Any decision made during the alternate dispute resolution concerning the validity of a services-level appeal, should be based on the documentation available to the insurer at the time of the decision. Allowing additional supporting documentation to be submitted at a later date, while minimally probative, oftentimes leads to unfair prejudice, confusing the issues, undue delay, wasting time, or needlessly presenting cumulative evidence.

RESPONSE: The Department agrees that the internal appeal process is the primary forum where disputes about the medical necessity of treatment and billing disputes should be addressed. The purpose of this rulemaking is to provide a uniform, simple-to-use and rapid procedure for appealing insurer decisions. The lengthy, expensive arbitration process should be available to handle complex disputes. Consistent with the foregoing principles, the Department believes that all the relevant information about a dispute should be produced as part of the internal appeal process and only under extraordinary circumstances should additional information be presented as part of the arbitration. However, the Department believes that the arbitration process itself is the best place for such determinations to be made. Claimants and respondents should object to the submission of information additional to that contained in the record of the internal appeal and absent extraordinary circumstances, the DRP should not admit such information.

COMMENT: One commenter requested the Department's response regarding two hypotheticals scenarios.

In the first scenario, the provider does not perform the surgical procedure and proceeds first with a pre-service appeal that contains the same information that was submitted with the

pre-certification request. The commenter questioned whether an insurer can reject/deny this appeal until they receive something more from the provider to substantiate the appeal. The commenter suggested that medical providers should be required to submit additional information beyond whatever accompanied the original precertification request. The commenter opined that a functional appeal process must require that a “valid” appeal contain additional documentation beyond the original precertification request to further support the medical provider’s basis for establishing medical necessity and clinical support as defined by the PIP Regulations. (See N.J.A.C. 11:3-4.2). The commenter also suggested that in arbitrations, providers should be limited to submission of only those documents contained in the prior precertification requests and appeals. Otherwise, the proposed regulatory appeal process is doomed to fail since medical providers (and their PIP attorneys who guide them through the appeal process) will have no incentive to treat this as anything more than “form over substance.” The commenter contends that claimant PIP attorneys in particular will be incentivized to advise their clients to withhold the submission of supporting information from appeals because their attorney’s fees only become payable upon a successful arbitration.

In the second hypothetical, the commenter presented the same facts, except the provider proceeds with the surgical procedure and submits a bill which is denied and the provider files a post-service appeal. The insurer reconsiders its denial and processes the bill at UCR. The commenter questioned whether the provider must file another post-service appeal of the UCR payment before proceeding to arbitration. The commenter suggested that they should require another appeal since this UCR issue had nothing to do with the original appeal. The commenter stated that on UCR appeals, the Department should require providers to submit supporting UCR proofs, so insurers can make an informed decision on the appeal. The commenter contends that

providers should be limited to proceed to arbitration with the proofs they submit on appeal because the current process allows them to file an appeal without UCR proofs, which then proceeds to arbitration where the provider then submits those proofs for the first time. The commenter believes that this is why there are so many UCR arbitrations, because insurers do not normally reconsider UCR issues on appeal since they have nothing from the provider upon which to reconsider the UCR payment.

RESPONSE: The Department does not agree with the commenter's suggestions for changes to the rules. As noted above in response to another comment, the Department has determined that it is not feasible to have a rule that requires providers to submit all additional information in an appeal. Insurers should note in the response to such appeals that no new information in support of the treatment has been provided. The Department agrees that, as a general principle, neither claimants nor respondents should submit information at an arbitration that was available but not submitted at the internal appeal. Again, as noted above in response to another comment, the Department declines to put this as a requirement in the rule. The Department believes that the arbitration process itself is the best place for such determinations to be made. Claimants and respondents should object to the submission of information additional to that contained in the record of the internal appeal - especially when available to the submitter at precertification and/or appeal - and absent extraordinary circumstances, the DRP should not admit such information.

COMMENT: One commenter recommends that the Department delay the effective date of these rules until 180 days after publication of the appeal forms in accordance with N.J.A.C. 11:3-4.7(c).

RESPONSE: The Department will delay the operative date of the adopted amendments and new rules until 180 days after the effective date of these rules to permit insurers to make changes in their policies and Decision Point Review plans.

COMMENT: One commenter sought clarification from the Department on whether insurers will be required to re-file the entire DRP Plan when making adjustments to their plans, or will insurers be able to re-file only the initial information letter.

RESPONSE: Insurers are not required to refile their entire DPR plan. They are only required to file those section of their plans that need to be changed in response to the adoption of the rule.

COMMENT: One commenter suggested that the Department use/require a standardized assignment of benefits (AOB) form. The commenter notes that this has been a point of contention between insurers and providers, but states that since there is a standardized DPR form, and that there will be standardized form for appeals this would be the next logical step.

RESPONSE: The commenter's suggestion is outside the scope of the rulemaking. Insurers are permitted to have different restrictions on their Assignment of Benefits forms, which would preclude a standardized form.

COMMENT: Two commenters believe that an ambulatory surgical center (ASC) should be exempt from both the pre- and post-service appeals process. They contend that as the ASC, they have nothing to do with the medical necessity of the case. The commenters stated that they do not utilize the DPR process, but that they are obligated to do a post-service appeal for bill denials. The commenters stated that the facility has no new information to send with said appeal

and several insurers will not accept an appeal from a facility stating that they will only accept one from the performing physicians. The commenters stated that if they do not do a post-service appeal, the insurer during arbitration will object because the commenter did not submit a post-service appeal.

RESPONSE: The Department does not agree with the commenter. An ASC is a “provider” as defined by N.J.A.C. 11:3-4.2 and, as such, is able to submit pre- and post-service appeals. There are several types of providers that are not involved in determining the medical necessity of a test, treatment, or procedure, but who submit bills to the insurer for the services they do render. When these providers disagree with the insurer’s reimbursement of the service, their recourse is a post-service appeal. The commenter is correct that in these circumstances, the determination of the medical necessity of a test, treatment, or procedure is being made by a different provider, and, therefore, that provider is responsible for submitting pre- or post-service appeals on the issue of medical necessity.

COMMENT: One commenter expressed concern about N.J.A.C. 11:3-4.7B(i), which states that insurers must respond to post-service appeals within 30 days. The commenter stated that given the volume of such appeals (it receives over 1,500 per month on average); this time restriction may not allow insurers to ensure that the appropriate individuals have an opportunity to properly review the appeal and determine whether an issue could be resolved without the need to proceed to arbitration. In order to handle appeals within the limited 30-day timeframe, companies may be forced to add staff, ultimately resulting in additional cost to policyholders. The commenter suggested that the expansion of the time within which to respond to post-service appeals from 30 to 40 days would permit a better opportunity to review of appeals before they proceed to dispute

resolution. Finally, the commenter stated that it would be beneficial for the Department to emphasize that its approval of the provisions of a DPR plan is final and binding on Dispute Resolution Professionals. The commenter believes that this clarification will ensure that provisions of an insurer's DPR plan will be enforced by the Dispute Resolution Professionals and prevent them from substituting their opinions on what is appropriate for those of the regulator.

RESPONSE: The Department does not agree with the commenter with regard to the time frame for insurers to render decisions on post-service appeals. The Department believes that a 30-day response time is reasonable. Many insurers have a 30-day response time for appeals in their current internal appeal procedures. With regard to the comments about the binding nature of DPR plans, the Department does not believe that Dispute Resolution Professionals have attempted to invalidate any provisions of an approved DPR plan. If the commenter is aware of any such decisions, please advise the Department.

COMMENT: One commenter expressed concern about the Department's Summary statement. The commenter stated that it is unsupported by any documentation or evidence. The commenter contends that insurers have not always been required to have an internal appeal process as part of their Decision Point Review plan. The commenter stated that this was only created by the Department under its last rule proposal. The commenter stated that there is no statutory authority for a mandatory appeal process as there is with regard to health insurance. The prior proposal process was not based on what was used by the Department for utilization management appeals in health plans, which was required by statute.

Another commenter objected to the Department's proposal and stated that the proposed amendments are still improper, except to the point that an optional, internal appeal if provided by an insurer must appear in their Decision Point Review plan. The commenter contends that there is no statutory basis for a mandatory, internal appeal prior to being able to file arbitration, and in fact, is contrary to current statutes. The commenter cited N.J.S.A. 39:6A-5.1 and stated that nowhere in the statute does it allow for a mandatory internal appeal prior to initiating a dispute resolution nor restrict an assignment of benefits to a provider of services. As such, the whole amendment is beyond the statutory authority and ultra-vires. The commenter stated that contrary to the Department's position in Bulletin 10-30, the prior and current proposal and current regulations do not have a mandatory internal appeal requirement. The current regulations allow for an optional ("to permit"), internal appeal. However, if the insurer had an internal appeal option, it must be included in the Decision Point Review plan. The commenter believes that the Department misinterpreted the "shall" as applying to having an appeal rather than having to include it in the Plan if offering an optional, internal appeal.

The commenter argued that the Department stated that the "new appeal process is based on that used by the utilization management appeals in health plans." The commenter contends that this statement is misplaced and contrary to the appeals in health insurance plans. Health insurance arbitration has a mandatory 90-day internal appeal process by statute (See N.J.S.A. 1:48A-7.12 and 26:2S-11).

The commenter contends that there is no statutory authority for a mandatory, internal appeals process in PIP under N.J.S.A. 39:6A-1 et seq. A Decision Point Review plan does not have to include pre-certification, restrictions on assignment, mandatory networks, or an appeal process. Only if an insurer is going to allow for the same, does the regulation require those items

to be included in the Decision Point Review plan pursuant to N.J.A.C. 11:3-4.7. The rulemaking places an additional requirement and hurdle on providers with assignments that is not allowed by statute and for a significantly less amount of time than allowed even under health insurance plans.

The commenter argued that even the current rulemaking's language allows providers who have been assigned benefits a rapid review of an adverse decision by an insurer. He contends that the proposed language continues to indicate under N.J.A.C. 11:3-4.7B(a) that the internal appeals process shall permit a provider to obtain a rapid review of an adverse decision.

The commenter believes that the burden this will place on individual medical providers is unreasonable and punitive. He questioned if medical providers should stop treating patients in need of medically necessary treatment so that they can open the mail, review routing denial letters, for appeal purposes.

Finally, the commenter expressed concern that ultimately, it is the consumer who will be harmed because he or she will not be able to obtain the medically necessary testing and treatment or will have to fight for the treatment and the bills to be paid on his or her own. The commenter stated that of the more than 700 arbitrations his office filed in 2014, none of those denials were overturned via the internal appeals process and so they had to go to arbitration. He contends that this simply wasted the resources of the medical providers, delayed treatment for the injured persons, and ultimately added to the costs of PIP. The same or similar reviewing doctors on behalf of the insurers continue to deny the claim for the vendor or insurer despite internal appeals. The commenter contends that of the thousands of claims that his office has handled over the last five years, that he can count on one hand the number of times that the insurance insurer reversed its denial on appeal.

RESPONSE: The Department does not agree with the commenter. While it is true that an internal appeal process for PIP disputes is not specifically required by statute, the Commissioner, pursuant to N.J.S.A. 39:6A-4, has broad authority to establish PIP benefits under the policy. The requirement that insurer Decision Point Review plans include an internal appeal process was included in amendments proposed to the Medical Protocols Rule in 2003, after initially being required in 1999, by Department Bulletin 99-07. Prior to the recent proposal to which the commenter refers, insurers could establish their own internal appeal process. This was amended in the current rulemaking to require a uniform internal appeal process for all insurers. The commenter is correct that insurers are not required to file Decision Point Review plans but they are not permitted to use any of the utilization review procedures, including penalty co-payments provided in N.J.A.C. 11:3-4, unless they have an approved Decision Point Review plan. The vast majority of automobile insurers have an approved Decision Point Review plan.

Federal Standards Statement

Executive Order No. 27 (1994) and N.J.S.A. 52:14B-1 et seq. require State agencies that adopt, readopt, or amend state rules that exceed any Federal standards or requirements to include in the rulemaking document a comparison with Federal law. A Federal standards analysis is not required in this instance because there are no Federal standards or requirements applicable to the adopted amendments and new rule.

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

11:3-4.7B Requirements for insurer internal appeals procedures

(a) (No change from proposal.)

(b) Insurers shall only require a one-level appeal procedure for each appealed issue before *[arbitration]* ***making a request for alternate dispute resolution in accordance with N.J.A.C. 11:3-5***. That is, each issue shall only be required to receive one internal appeal review by the insurer prior to *[arbitration]* ***making a request for alternate dispute resolution***. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than an appeal of what the insurer should reimburse the provider for that same service.

(c) – (i) (No change from proposal.)

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