INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF PROPERTY AND CASUALTY

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

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

Authorized By: Steven M. Goldman, 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, 39:6A-5.1 and 39:6A-5.2.

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

Proposal Number: PRN 2009-207

Submit comments by September 4, 2009 to:

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The agency proposal follows:

Summary

The Department is proposing to amend the Personal Injury Protection Medical Protocols and Alternate Dispute Resolution rules. The Department's proposed amendments further enhance these subchapters' standards which are intended to ensure that PIP medical benefits are provided as required by N.J.S.A. 39:6A-4 et. seq. The proposed amendments serve to promote the cost efficient provision of quality medical care to persons injured in automobile accidents.

N.J.A.C. 11:3-4.2 is being amended to add definitions for ambulatory surgical facility (or "ambulatory surgical center" (ASC), and "organized delivery system" (ODS).

The Department is amending N.J.A.C. 11:3-4.4 by adding a new subsection (d), which permits insurers to file policy language that waives the policy deductibles and copayments if an insured decides to get treatment from in-network providers in an ODS that has contracted with the insurer. Under this addition, the insured will be informed at the time of reporting a loss that, if he or she uses providers that are part of an ODS that has a contract with the auto insurer, the policy deductible and 20 percent co-payment will not be applied to such treatment. This would enable the insured to save money by not having to pay the deductible and copayment and, if necessary, to receive additional treatment under his or her PIP benefit since contracted fees in an ODS are typically lower than those charged by providers who are not in part of an ODS. Thus, this amendment will enable injured insureds who are unable to afford deductibles and copayments to receive more extensive medically necessary treatment of their injuries than they might otherwise have obtained. The insured will retain the option to go to a provider that is not in an ODS at any time during treatment, but the deductible and copayments will remain applicable to those medical services or treatments.

In addition, the Department's amendment permits insurers to consider the access fee charged by the ODS within policy limits for services with charges in excess of $10,000. This will provide an incentive for insurers to seek to use lower cost ODS services in high-value claims, which can generate considerable additional benefit dollars for the insured. In the example provided in the proposal, the insured would have an additional $3,375 available for treatment under the PIP coverage. N.J.A.C. 11:3-4.4(d) through (h) are being recodified as subsection (e) through (i). Along with being recodified, subsection (g) (recodified as subsection (h)) is being amended to reflect corresponding changes to the recodified rule provisions in the text. Subsection (f) (recodified as subsection (g)) is being amended to clarify that the penalty co-

payment applies for failure to use any of the voluntary networks permitted by N.J.A.C. 11:3-4.8(b).

N.J.A.C. 11:3-4.7(a) is proposed for amendment to conform the references in the text to the changes made in the codification of N.J.A.C. 11:3-4.4(d) through (f) as N.J.A.C. 11:3-4.4(e) through (g).

A proposed amendment to N.J.A.C. 11:3-4.7(c)2 addresses the subject of some recent complaints made to the Department. The amendment will prohibit insurers from requiring precertification of the evaluation and management visit for a new patient. In order to develop a plan of care and get the information necessary to make a precertification request for treatment or diagnostic testing, the provider needs to be able to examine the patient and take a history.

A proposed amendment to N.J.A.C. 11:3-4.7(c)3 deletes a provision that requires insurers to put their Decision Point Review Plan on the World Wide Web and provide the Department with the Universal Resource Locator (URL) of such Plans so that the Department can maintain a directory of such plans on its web site. The Department is deleting this provision because it does not have the resources to keep the listing current. The Department encourages insurers to make information concerning its Decision Point Review plans as accessible as possible for insureds and providers.

N.J.A.C. 11:3-4.7(d)6 is proposed for amendment to conform the reference in the text to the changes made in the codification of N.J.A.C. 11:3-4.4(d) as N.J.A.C. 11:3-4.4(e).

N.J.A.C. 11:3-4.8(a) is being amended to eliminate out-of-date citations to N.J.A.C. 8:38A-4.10 concerning network adequacy standards for carriers offering health benefits plans that are managed care plans and N.J.A.C. 8:38B for organized delivery systems because those

rules have been recodified under prior adoptions as N.J.A.C. 11:24A-4.10 and 11:24B, respectively

N.J.A.C. 11:3-4.8(b) is being amended to add a provision that permits insurers to have voluntary networks for services provided in ambulatory surgery facilities. Such networks can provide a considerable saving for services provided to insureds in such facilities.

N.J.A.C. 11:3-4.8(c)1 is proposed for amendment to conform the references in the text to the changes made in the codification of N.J.A.C. 11:3-4.4(f) as N.J.A.C. 11:3-4.4(g).

N.J.A.C. 11:3-5.4(b)3 is being amended to require dispute resolution plans to include the standard under which a dispute resolution professional shall grant an expedited hearing, namely a demonstration that immediate or irreparable loss or damage will result in the absence of such relief. The "immediate and irreparable harm" standard has been in effect for many years and has been contained in the dispute resolution organization's plan, which is approved by the Commissioner. Consequently, the Department believes that it is appropriate to include the standard as a requirement in these rules.

A new N.J.A.C. 11:3-5.4(b)6 is being proposed to include a new provision. This new provision requires the dispute resolution organization's plan to include a procedure whereby a medical review organization (MRO) can provide a speedy determination of the medical necessity of treatment or testing when an insurer has denied a decision point review or precertification sought by the insured. The Department has received complaints that patients whose requests for treatment or testing have been denied by an insurer as not medically necessary may have to wait months for a decision in the arbitration system. While there is a provision for an expedited hearing for cases where the failure to get the treatment may cause immediate and irreparable harm, many disputes about the medical necessity for treatment do not meet this standard. The

amendment requires that the dispute resolution organization's plan contain a procedure whereby a party may refer an issue of medical necessity directly to the MROs that are already contracted with the Department. This will enable the MROs to make a determination of medical necessity in a very short period of time, usually less than 30 days. In this way, disputes that only involve the medical necessity of a treatment or test can be expeditiously resolved. Disputes that include other issues such as billing can be handled by the normal arbitration process. The current N.J.A.C. 11:3-5.4(b)6 is being recodified as paragraph (b)7.

N.J.A.C. 11:3-5.10(c) is being amended to require MROs to include in an application for certification the fee that the MRO proposes to charge for determinations it may make as set forth in N.J.A.C. 11:3-5.8(a). N.J.A.C. 11:3-5.11(a), which sets the fee for an MRO determination, is being proposed for deletion. The Department has determined that it is not feasible to set the fee for such determinations by rule. As noted above, the amendment to N.J.A.C. 11:3-5.10(c) requires that the amount of the fee be included in the materials submitted by the MRO to the Department as part of the certification process.

A 60-day comment period is provided for this notice of proposal and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The Department's proposed amendments will promote the cost efficient provision of quality medical care to persons injured in automobile accidents. The Department believes that these rules will have a positive social impact on insureds and insurers. The amendment to N.J.A.C. 11:3-4.8(b) to permit insurers to have a voluntary network for services provided in

ambulatory surgery facilities should provide savings for services provided to insureds in such facilities.

The amendment to N.J.A.C. 11:3-5.4(b)6, which requires that the dispute resolution organization's plan include a procedure whereby a medical review organization can provide a speedy determination of the medical necessity of treatment or testing, will be beneficial to patients whose requests for treatment or testing have been denied by an insurer as not medically necessary. The effect of the proposed amendments should be that such patients will no longer have to wait months for decisions on such disputes in an arbitration system.

The Department's amendment to N.J.A.C. 11:3-4.4(d) permits insurers to file policy language that waives the policy deductible and co-pays if an insured decides to get treatment from in-network providers in an ODS that has contracted with the insurer. This will enable the insured to save money by not having to pay the deductible and copayment and, if necessary, to receive additional treatment under his or her PIP benefit since contracted fees in an ODS are typically lower than those charged by providers who are not in part of an ODS. Thus, this amendment will enable insureds who are unable to afford deductibles and copayments to obtain more extensive medically necessary treatment of their injuries than they might otherwise have obtained, which the Department considers a beneficial social impact.

Economic Impact

The proposed amendments will affect private passenger automobile insurers and insureds. The Department believes that, by amending N.J.A.C. 11:3-4.8(b)6 to permit insurers to have voluntary networks for services provided in ambulatory surgery facilities, PIP medical

expense savings for the services provided to insureds in such facilities may be realized, thereby containing a factor which exerts upward pressure on automobile insurance rates.

The Department's amendment to N.J.A.C. 11:3-4.4(d) permits insurers to file policy language that waives the policy deductible and co-pays if an insured decides to get treatment from in-network providers in an ODS that has contracted with the insurer. As noted in the Summary and Social Impact, this would enable the insured to save money both by not having to pay the deductible and copayment and, if necessary, by receiving more treatment from his or her PIP benefit. The Department believes that, although policy deductibles and copayments will be permitted to be waived pursuant to this proposed amendment, the savings anticipated from the ODS network fee agreements will also be beneficial to insurers.

Federal Standards Statement

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

Jobs Impact

The Department does not believe that these proposed amendments will cause any jobs to be generated or lost.

Agriculture Industry Impact

The proposed amendments will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The Department's proposed amendments will apply to "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the proposed amendments apply to small business, they will apply to New Jersey domestic insurers authorized to transact private passenger automobile insurance and/or motor bus expense coverage in this State.

All automobile insurance policies are required to provide the PIP medical expense benefits as set forth in N.J.S.A. 39:6A-4. As was discussed in the Economic Impact, the cost of the Department's proposed amendments will not impose an undue burden on insurers. The Department believes that no additional professional services will be required in order to comply with the proposed amendments. The proposed amendments further enhance these subchapters' purpose which is to ensure that PIP medical benefits are provided as required by N.J.S.A. 39:6A-4 et seq. In order to ensure that all PIP coverage provided by automobile insurers meets the minimum requirement of these subchapters, it is appropriate that these amendments offer no differing compliance requirements for automobile insurers based on business size.

Smart Growth Impact

The proposed amendments will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The proposed amendments will not have an impact on housing affordability because the amendments relate to personal injury protection benefits, medical protocols and diagnostic tests.

Smart Growth Development Impact

The Department believes that there is an extreme unlikelihood that these amendments will evoke a change in housing production in Planning Areas 1 and 2 or within the designated centers under the State Development and Redevelopment Plan in New Jersey because the proposed amendments address personal injury protection benefits, medical protocols and diagnostic tests.

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

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

11:3-4.2 Definitions

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

"Ambulatory surgery facility" or (ASC) "ambulatory surgical center" means:

1. A surgical facility, licensed as an ambulatory surgery facility in New Jersey in accordance with N.J.A.C. 8:43A in which ambulatory surgical cases are performed and which is separate and apart from any other facility license. (The ambulatory surgery facility may be physically connected to another licensed facility, such as a hospital, but is corporately, financially and administratively distinct, for example, it uses a separate tax-id number); or

2. A physician-owned single operating room in an office setting that is certified by Medicare.

. . .

"Organized delivery system" (ODS) means an organized delivery system certified or licensed pursuant to N.J.S.A. 17:48H-1 et seq., N.J.A.C. 11:22-4 or N.J.A.C. 11:24B.

. . .

11:3-4.4 Deductibles and co-pays

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

(d) An insurer may file policy language that waives the co-payment and deductible in (a) and (b) above when the insured receives medical treatment from a provider that is part of an ODS that has contracted with the insurer. The insured shall not

be required to elect to use the providers or facilities in such an ODS either at issuance of the policy or when the claim is made.

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

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

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

2. The actual ODS access fee or 25 percent of the reduction in charges resulting from the use of the ODS provider, whichever is less, may be included within the policy limits for any single bill from an in-network provider in the ODS with billed charges of $10,000 or more.

Example: A $10,000 charge is reduced by the ODS contract with the insurer by 40 percent to $5,500. The insurer could include the ODS access fee or $1,125 (25 percent of the $4,500 reduction), whichever is less, within the policy limits.

Recodifying existing (d) - (e) as **(e) - (f)** (No change in text.)

[(f)] **(g)** 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 **the** medically necessary **[**diagnostic tests as specified**] non-emergency benefits listed** in N.J.A.C. 11:3-4.8(b)**[**, durable medical equipment and/or prescriptions**].**

[(g)**] (h)** For the purpose of the co-payments permitted in **[**(d), (e) and (f)**] (e), (f) and (g)** above, the percentage reduction shall be applied to the amount that the insurer would otherwise have paid to the insured or the provider after the application of the provisions of N.J.A.C. 11:3-29. Insurers may apply the co-payments and deductibles in (a) through **[**(f)**] (g)** above in any order, provided that they use the same order of application for all insureds. Upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall make its co-payment and deductible application methodology available to the insured and the treating medical provider upon request.

[(h)**] (i).** (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. 11:3-4.4**[**(d), (e) and (f)**] (e), (f) and (g)** unless it has an approved decision point review plan.

1. (No change.)

(b) (No change.)

(c) A decision point review plan filing shall include the following information:

1. (No change.)

2. Identification of any specific medical procedures, treatments, diagnoses, diagnostic tests, other services or durable medical equipment that are subject to precertification.

The inclusion of precertification requirements in a decision point review plan is optional. The medical procedures, treatments, diagnoses, diagnostic tests or durable medical equipment required to be precertified shall be those that the insurer has determined may be subject to overutilization and that are not already subject to decision point review. **The insurer shall not require the precertification of a new-patient evaluation and management visit that is necessary for the provider to develop the plan of care that is incorporated into a precertification request for treatment or diagnostic testing**;

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;**]**

4. – 8. (No change.)

(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 insureds and providers to use, the Commissioner may by Order require the use of uniform forms, layouts and language of information materials.

1. – 5. (No change.)

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)**]** **(e)**;

7. – 9. (No change.)

(e) – (g) (No change.)

11:3-4.8 Voluntary networks

(a) No insurer shall file a decision point review plan utilizing a voluntary network or networks unless the network is a health maintenance organization licensed pursuant to N.J.S.A. 26:2J-1 et seq.; or approved by the Department as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37 and **[**8:38A**]** **11:24A**-4.10; or approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6**[**,**];** or is licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 and **[**8:38B**]****11:24B**.

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

1. – 3. (No change.)

4. Durable medical equipment with a cost or monthly rental in excess of $50.00; **[**or**]**

5. Prescription drugs**[**.**]** **; or**

6. Services, equipment or accommodations in an ambulatory surgery facility.

(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)**]****(g).**

2. (No change.)

(d) - (e) (No change.)

SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

11:3-5.4 Dispute resolution organizations

(a) (No change.)

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

1. - 2. (No change.)

3. The plan shall provide the assigned dispute resolution professional with sufficient authority to provide all relief and to determine all claims arising under PIP coverage, but may provide for limited, procedural or emergent matters to be determined by one or more specially designated dispute resolution professionals;

i. Emergent or expedited relief shall be granted upon demonstration that immediate and irreparable loss or damage will result in the absence of such relief;

4. (No change.)

5. The plan shall provide for the prompt, fair and efficient resolution of PIP disputes, after a hearing by the assigned dispute resolution professional, but shall also provide that alternate procedures may be utilized when appropriate, which may include mediation, conferences to promote consensual resolution and expedited hearings upon receipt of a medical review organization report, consistent with principles of substantive law and rules adopted by the Commissioner; **[**and**]**

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

[6.**]** **7.**. (No change in text.)

(c) (No change.)

11:3-5.10 Medical review organization certification process

(a) - (b) (No change.)

(c) The MRO application shall include the following:

1. – 8. (No change.)

9. The fee(s) for determinations by the MRO;

Recodified existing 9. and 10. as **10. and 11**. (No change in text.)

(d) – (i) (No change.)

11:3-5.11 Fees

[(a) The initial fee for a determination by a Medical Review Organization shall be $575.00. The Commissioner may adjust the fee every two years by order based on the rise in the medical component of the Consumer Price Index as published by the United States Department of Labor. Such fee adjustments shall be initiated in this subchapter through a notice of administrative change published in the New Jersey Register.

(b)**]** When a mental or physical examination is performed in connection with the medical review organization's services, the health care provider performing the examination shall be paid the fee provided for that service set forth on the Department's medical fee schedule, N.J.A.C. 11:3-29.

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