

“Medical expense” means the reasonable and necessary expenses for treatment or services rendered by a provider, including medical, surgical, rehabilitative and diagnostic services and hospital expenses and reasonable and necessary expenses for ambulance services or other transportation, medication and other services, subject to limitations as provided for in the policy forms that are filed and approved by the Commissioner.

“Medically necessary” or “medical necessity” means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths in the Appendix, as applicable;
2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
3. Does not include unnecessary testing or treatment.

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

“Non-medical expense” means charges for those:

1. Products and devices, not exclusively used for medical purposes or as durable medical equipment, such as any vehicles, durable goods, equipment, appurtenances, improvements to real or personal property, fixtures; and
2. Services and activities such as recreational activities, trips and leisure activities.

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

“Precertification” or “precertification request” means the procedures in an insurer’s approved decision point review plan for the insurer to receive notice and respond to requests for listed specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.

“Standard automobile insurance policy” or “standard policy” means a private passenger automobile insurance policy issued in accordance with N.J.S.A. 39:6A-4.

Amended by R. 2000 d.454, effective November 6, 2000.  
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

Inserted “Diagnostic test”.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote “Decision point”, added “Decision point review”, “Emergency personal injury protection coverage”, “Insurer”, “Network”, “PIP vendor” and rewrote “Pre-certification”.

#### Case Notes

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. *Quality Health Care v. DOBI*, 348 N.J.Super. 272, 791 A.2d 1085.

#### 11:3-4.3 Personal injury protection benefits applicable to basic and standard policies

(a) Personal injury protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident up to the limits set forth in the policy and in accordance with this subchapter.

(b) Personal injury protection coverage shall only provide reimbursement for clinically supported necessary non-medical expenses that are prescribed by a treating medical provider for a permanent or significant brain, spinal cord or disfiguring injuries.

#### 11:3-4.4 Deductibles and co-pays

(a) Each insurer shall offer a standard \$250.00 deductible and 20 percent copayment on medical expense benefits payable between \$250.00 and \$5,000.

(b) Each insurer shall also offer, at appropriately reduced premiums, the option to select medical expense benefit deductibles of \$500.00, \$1,000, \$2,000 and \$2,500 in accordance with the following provisions:

1. Any medical expense deductible elected by the named insured shall apply only to the named insured and any resident relative in the named insured’s household, who is not a named insured under another automobile policy and not to any other person eligible for personal injury protection benefits required to be provided in accordance with N.J.S.A. 39:6A-3.1 and 39:6A-4;

2. Premium credits calculated and represented as a percentage of the applicable premium shall be provided for each deductible. The premium percentage shall be uniform by filer on a statewide basis; and

3. The deductible option elected by the named insured shall continue in force as to subsequent renewal or replacement policies until the insurer or its authorized representative receives a properly executed coverage selection form to eliminate or change the deductible.

(c) All deductibles and co-pays in (a) and (b) above shall apply on a per accident basis.

(d) Failure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided

between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

Example: Assume that all days are business days and the insurer's Decision Point Review Plan gives the insurer three days to respond to decision point review and precertification requests. By the terms of the insurer's Decision Point Review Plan, a treating medical provider is required to make a decision point review request on day 21 of treatment (time notification was required). The provider does not give the required notification in a timely manner but continues to treat the patient. The provider then makes the notification and it is received by the insurer on day 35 (time proper notification made). The insurer responds on day 38 that the treatment can proceed (time for insurer to respond). Assuming that the treatment made between day 21 and 38 was medically necessary, it is subject to the 50 percent co-payment.

1. No insurer may impose the additional co-payment where the insurer received the required notice but failed to act in accordance with its approved decision point review plan to request further information, modify or deny reimbursement of further treatment, diagnostic tests or durable medical equipment.

(e) An insurer may require that the insured advise and inform the insurer about the injury and the claim. This requirement may include the production of information from the insured regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment.

1. This information may be required to be provided as promptly as possible after the accident, and periodically thereafter.

2. An insurer may impose an additional co-payment as a penalty for failure to supply the required information. Such penalties shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. The additional co-payment shall be an amount no greater than:

i. Twenty-five percent when received 30 or more days after the accident; or

ii. Fifty percent when received 60 or more days after the accident.

3. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

4. Information about this requirement and how to comply with it shall be included in the informational materials required by N.J.A.C. 11:3-4.7(d).

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

(g) (Reserved).

(h) For private passenger automobiles insured under a commercial automobile insurance policy where no natural person is a named insured, insurers shall only provide personal injury protection with medical expense benefits coverage in an amount not to exceed \$250,000 per person, per accident, with the deductible and copayment amount set forth in (a) above.

Amended by R. 2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

Inserted a new (e); and recodified former (e) as (f).

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote (d); added (f); recodified former (f) as (h).

#### 11:3-4.5 Diagnostic tests

(a) The personal injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, which have been determined to yield no data of any significant value in the development, evaluation and implementation of an appropriate plan of treatment for injuries sustained in motor vehicle accidents:

1. (Reserved)

2. Spinal diagnostic ultrasound;

3. Iridology;

4. Reflexology;

5. Surrogate arm mentoring;

6. Surface electromyography (surface EMG);

7. (Reserved); and

8. Mandibular tracking and stimulation.

(b) The personal injury protection medical expense benefits coverage shall provide for reimbursement of the following diagnostic tests, which have been determined to have value in the evaluation of injuries, the diagnosis and development of a treatment plan for persons injured in a covered accident, when medically necessary and consistent with clinically supported findings: