1. The plan shall include procedures for the injured person or his or her designee to provide prior notice to the insurer or its designee together with the appropriate clinically supported findings that additional treatment or the administration of a test in accordance with N.J.A.C. 11:3–4.5(b) is medically necessary, as follows:

i. The prompt review of the notice and supporting materials submitted by the provider and authorization or denial of reimbursement for further treatment or tests;

ii. The scheduling of a physical examination of the injured person in accordance with (b)2 below where the notice and supporting materials and other medical records if requested, are not sufficient to authorize or deny reimbursement of further treatment or tests; and

iii. Any denial of reimbursement for further treatment or tests shall be based on the determination of a physician.

2. A physical examination of the injured party as part of a decision point review shall be conducted as follows:

i. The insurer shall notify the injured person or his or her designee that a physical examination is required;

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

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

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

v. The treating provider or injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided no later than the time of the examination; and

vi. The insurer shall notify the injured person or his or her designee whether reimbursement for further treatment or tests is authorized as promptly as possible but in no case later than three days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

3. The plan may provide that failure to notify the insurer as required in the plan; failure to provide medical records; or failure to appear for the physical examination scheduled in accordance with b(2) above shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical goods and non-medical expenses that are incurred after notification to the insurer is required but before authorization for continued treatment or the administration of a test is made by the insurer. No insurer may impose the additional co-payment where the insurer received the required notice but failed to act in accordance with its approved decision point plan to authorize or deny reimbursement of further treatment or tests.

4. The plan shall avoid undue interruptions in a course of treatment.

5. Insurers are encouraged to provide decision point review plans that permit the treating provider to submit for review a comprehensive treatment plan so as to minimize the need for piecemeal review.

(c) All decision point review plans, including a pre-certification program filed and approved pursuant to N.J.A.C. 11:3–4.8 shall contain provisions for the disclosure of the procedures in the decision point review plan to injured persons and providers.

1. The information required to be disclosed pursuant to this subsection shall include a description of:

i. The financial responsibility of the injured person including co-payments and deductibles;

ii. The financial responsibility of the provider for providing treatment or administering tests without authorization from the insurer; and

iii. How authorization for treatment and the administration of tests may be obtained.

2. In addition to the description of the plan set forth in the policy form, the insurer shall provide any information necessary to comply with decision point review in accordance with this rule to the injured person, the provider, or both, promptly upon receiving notice of the claim.

(d) No decision point requirements shall apply within 10 days of the insured event. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Deleted a former (c); and recodified former (d) and (e) as (c) and (d).

11:3–4.8 Precertification

(a) Insurers may require precertification of certain specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.

(b) Precertification requirements shall be included with a decision point review plan submission but the medical procedures, treatments, diagnostic tests, durable medical equipment or other services that require precertification shall be identified separately from decision point review.

New Jersey State Library

(c) No precertification requirements shall apply within 10 days of the insured event.

(d) Precertification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or test.

(e) An insurer that wishes to use precertification shall designate a licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that:

1. Any utilization decision to deny reimbursement for further testing or treatment because the treatment or diagnostic tests are not medically necessary, shall be made by a physician. In the case of treatment prescribed or provided by a dentist, the decision shall be by a dentist;

2. A utilization management decision shall not retrospectively deny payment for treatment provided when prior approval has been obtained, unless the approval was based upon fraudulent information submitted by the person receiving treatment or the provider; and

3. The utilization management program shall be available, at a minimum, during normal working hours to respond to authorization requests.

(f) The insurer shall include precertification requirements in the information about its decision point review plan that will be given to consumers with new and renewal policies and upon notice of a claim. The consumer information shall include at a minimum the items in N.J.A.C. 11:3–4.7(d).

(g) A precertification plan may include provisions that require injured persons to obtain durable medical equipment directly from the insurer or its designee.

(h) Policy forms may include an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with precertification requirements.

(i) Precertification shall avoid undue interruptions in a course of treatment.

(j) Insurers are encouraged to permit a treating provider to submit a comprehensive treatment plan for precertification so as to minimize the need for piecemeal review.

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

11:3–4.9 Assignment of benefits; public information

(a) Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.

(b) An insurer shall identify documents containing proprietary information in its decision point review plan submission. Documents containing proprietary information shall be confidential and shall not be subject to public inspection and copying pursuant to the "Right-to-Know" law, N.J.S.A. 47:1A–1 et seq. The Department shall notify the insurer prior to responding to any public record request for proprietary information.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Designated existing section as (a) and added (b).

11:3–4.10 Reporting requirements

(a) Insurers shall file with the Department a completed monthly decision point review/precertification implementation report (Appendix Exhibit 11, incorporated herein by reference) on the 10th day of each month which reflects the reported activity as of the last day of the premium month.

(b) The report referred to in (a) above shall be filed on paper and on diskette or by e-mail using an Excel spreadsheet format with data contained in one computer file. This filing shall be e-mailed to cday@dobi.state.nj.us or mailed to:

New Jersey Department of Banking and Insurance
Office of Property and Casualty Insurance
Attn: Statistical Unit
PO Box 325
Trenton, NJ 08625–0325

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

APPENDIX

TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATHS

Exhibit 1

Glossary of Terms

Acute Disease—a disease with rapid onset and short course to recovery. Not chronic.

Care Path—a recommended extensive course of care based on professionally recognized standards.

Case Management—a method of coordinating the provision of healthcare to persons injured in automobile accidents, with the goal of ensuring continuity and quality of care and cost effective outcomes. The Case Manager may be a nurse, social worker, or physician, preferably with certification in case management.

Cauda Equina—a collection of spinal roots that descend from the lower part of the spinal cord. They exist in the lower part of the vertebral canal.

Chronis Disease—a disease with long duration that changes little and progresses slowly. The apposite of acute.

Clinical Evaluation—the evaluation of the symptoms and signs of an injured person by a treating practitioner.

Conservative Therapy—treatment which is not considered aggressive; avoiding the administration of medicine or utilization of invasive procedures until such procedures are clearly indicated.

Contusion—an injury to underlying soft tissues when the skin is not broken. A bruise.

Diagnostic Evaluation—the process of differentiating between two or more diseases with similar signs and symptoms through the use of evaluative procedures such as imaging, laboratory, and physical tests.

Herniation—the protrusion or projection of an organ or other body structure through a defect or natural opening in a covering membrane, muscle, or bone.

Independent Consultative Opinion—physical examination by a physician of similar specialty to the injured person's treating practitioner to provide a second medical opinion. The independent physician may support, refute, or provide alternatives to the current diagnosis and treatment plans.

Non-Compliant—a patient who wilfully chooses not to participate in the treatment plan agreed upon by the patient and his/her healthcare provider and does not have secondary issues such as lack of transportation, pre-existing conditions or comorbidities.

PT—Physical Therapy—the therapeutic use of heat, light, water, electricity, massage, exercise, and non-ionizing radiation in treatment of injuries to the soft tissue and muscles/skeleton. PT rendered to persons injured in automobile accidents must be provided by a person whose scope of licensure includes physical therapy.

Radicular—pertaining to a root (such as a nerve root) disorder.

Radiculopathy—a disorder of a nerve root.

Sign—an objective manifestation, usually indicative of a disease or disorder. Signs can be observed by the clinician, as opposed to symptoms, which are perceived only by the affected individual.

Soft Tissue Injury—injuries sustained to the muscle, skin, connective tissue.

Spine—the vertebral column.

Spinal Shock—an acute condition resulting from spinal cord severance. Characterized by a total sensory loss and loss of reflexes below the level of injury and flaccid paralysis.

Sprain—an injury at a joint where a ligament is stretched or torn.

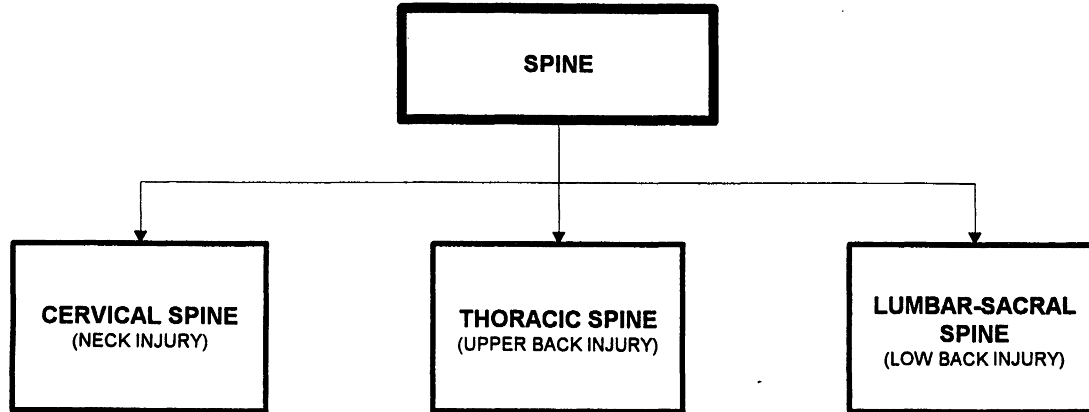
Strain—an injury caused by the over-stretching or tearing of a muscle or tendon. In its most severe form, the muscle ruptures.

Symptom—a subjective manifestation, usually indicative of a disease or disorder. Symptoms are experienced only by the affected individual, as opposed to signs, which can be observed by others.

Treatment Plan—specific medical, surgical, chiropractic, acupuncture, or psychiatric procedures used to improve the signs or symptoms associated with injures sustained in automobile accidents, e.g., physical therapy, surgery, administration of medications, etc.

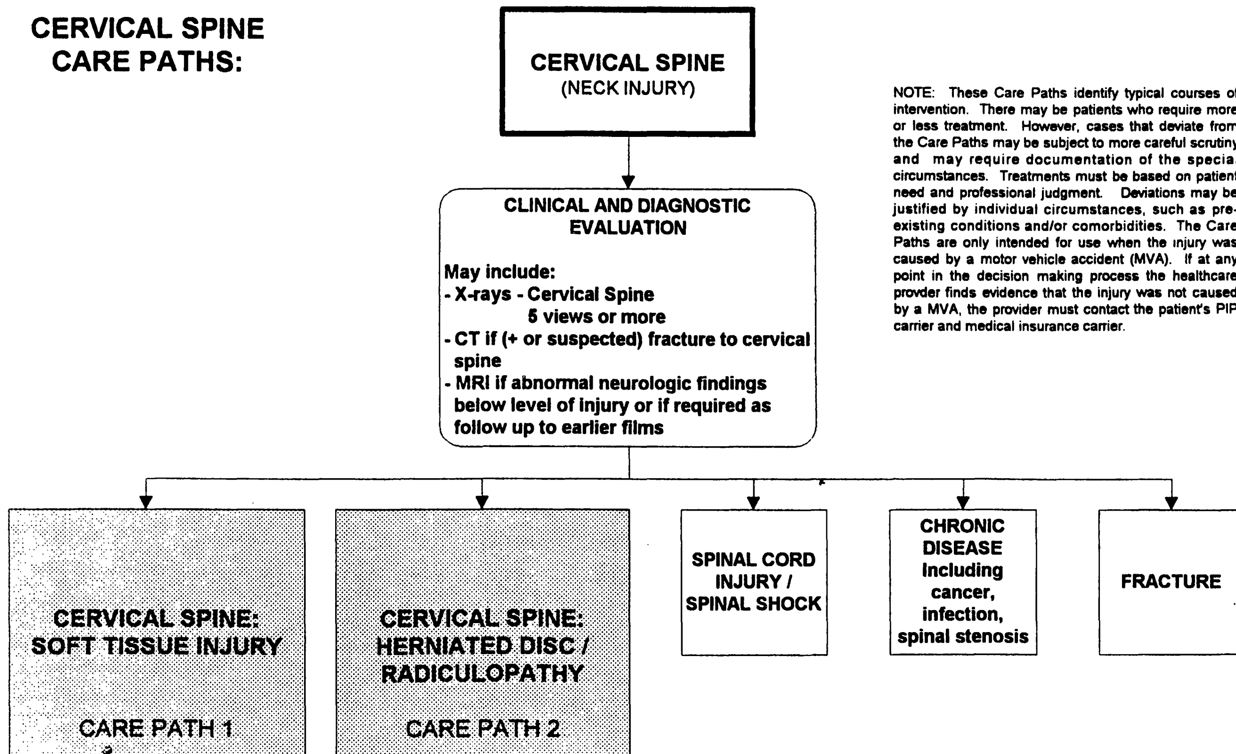
EXHIBIT 2

TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATH OVERVIEW



The following flow charts address the three anatomical areas of spinal injuries; Care Paths 1 through 6 have been developed for the conditions noted in the shaded boxes.

CERVICAL SPINE CARE PATHS:

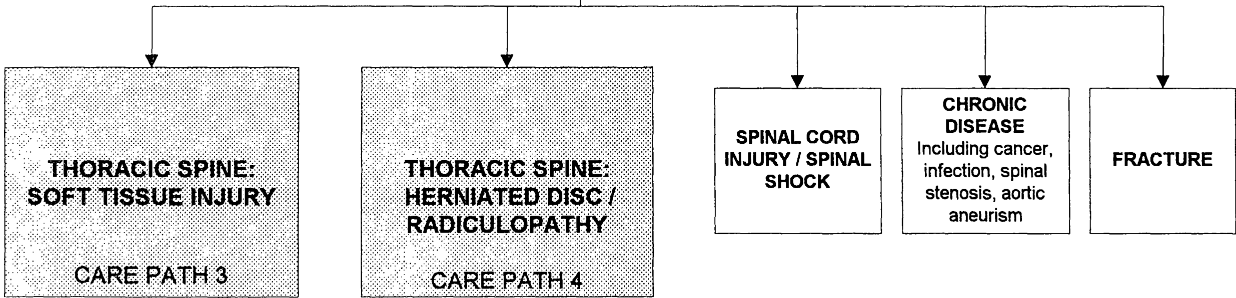


NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

THORACIC SPINE CARE PATHS:

THORACIC SPINE
(UPPER BACK INJURY)

CLINICAL AND DIAGNOSTIC EVALUATION
May include:
- **X-rays - Thoracic Spine (2-3 views or more)**
- **CT if (+ or suspected) fracture to thoracic spine**
- **MRI if abnormal neurologic findings or if required as follow up to earlier films**



LUMBAR-SACRAL SPINE CARE PATHS:

LUMBAR-SACRAL SPINE
(LOW BACK INJURY)

CLINICAL AND DIAGNOSTIC EVALUATION
May include:
- **X-rays - LS Spine (3 views or more)**
- **CT if (+ or suspected) fracture to LS spine**
- **MRI if abnormal neurologic findings or if required as follow up to earlier films**

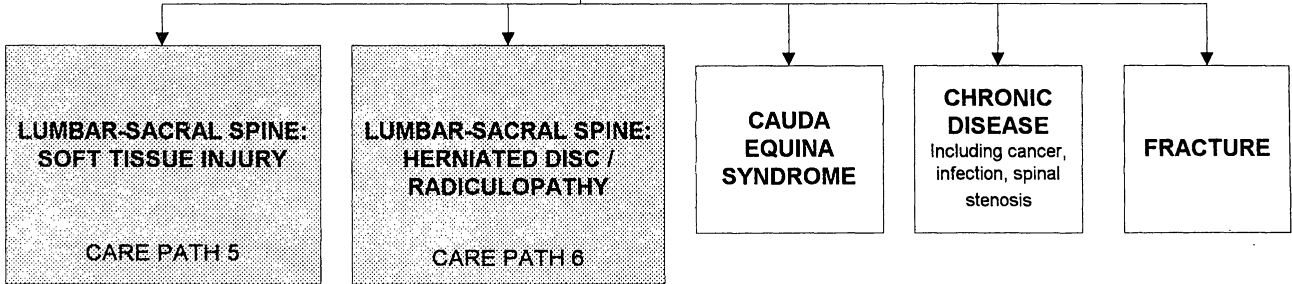


EXHIBIT 3

CARE PATH 1

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

CERVICAL SPINE SOFT TISSUE INJURY (STRAIN/SPRAIN/CONTUSION WHIPLASH) OF THE NECK

↓

CONSERVATIVE THERAPY (up to 4 weeks)

- Provider office visits (up to 5)
- Medications[1]
- Consider soft neck collar (maximum 48 hours)
- Increasing exercise
- Consider PT program (2-3 times per week, up to 4 weeks)[3]
- Spinal manipultaion2 (1-3 visits per week, up to 4 weeks)

(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

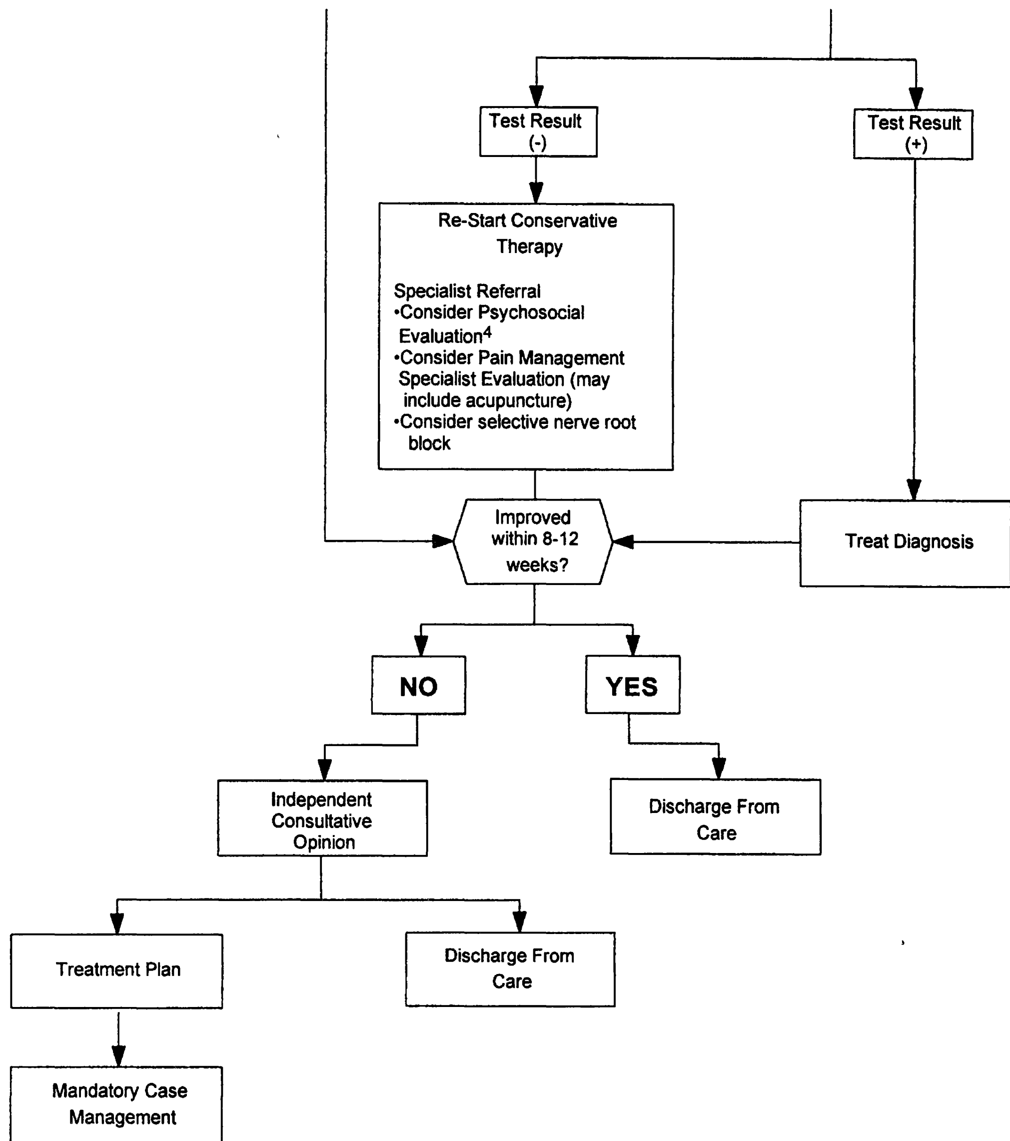
4 WEEKS ↓ **POST INJURY**

Improvement in symptoms based on objective findings?

YES
- Symptoms Resolved → Discharge from Care
- Symptoms Minimally Resolved → Patient Compliant with Treatment Plan?
  - **NO** → Continue Conservative Therapy
    - Begin or continue PT
    - Consider Specialist Referral
    - Consider Psychosocial Eauluation[4]
  - **YES** → Continue Conservative Therapy
    - Begin or continue PT
    - Consider Specialist Referal
    - Pain Management up to 3 visits (may include acupuncture)

NO
- Symptoms Worse or Unresolved → Development of Radiculopathy?
  - **NO** → Diagnostic Re-evaluation
    - May include:
    - CBC
    - ESR
    - X-ray, CT, MRI (if not previously done)
    - Bone scan
  - **YES** → Go To Care Path 2 Cervical Herniated Disc/ Radiculopathy

1, 2, 3, 4 See Addendum to Care Paths



ICD-9 CODES

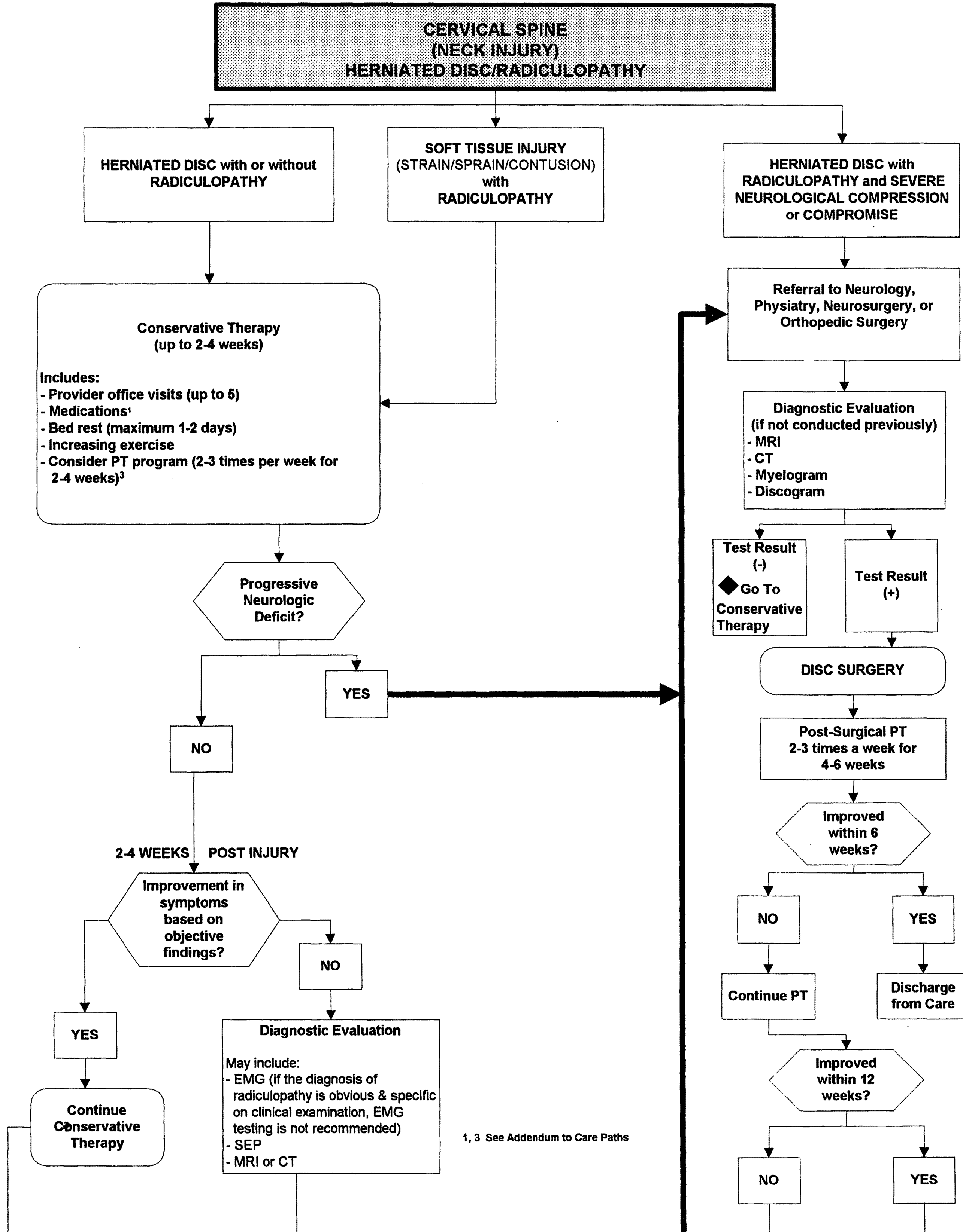
728.0
728.85
739.0
739.1
847.0
847.9
922.3
922.31
953.0

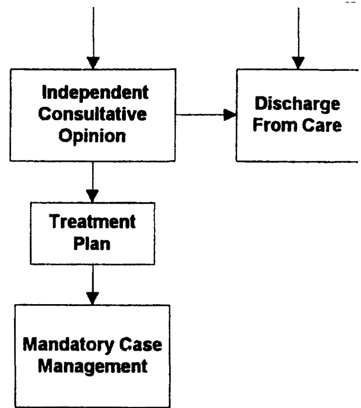
4 See Addendum to Care Paths

CARE PATH 1

EXHIBIT 4

CARE PATH 2





Test Result (-) After Evaluation for Surgery

Test Result (-)

Test Result (+)

Willing to Consider Surgery?

NO

YES

◆Continue Conservative Therapy

Specialist Referral
- Consider Psychosocial Evaluation[4]
- Consider Pain Management Specialist Evaluation (may include acupuncture)
- Consider selective nerve root block
- Continue PT
- Consider limited course of spinal manipulation (if no improvement within 1 month, discontinue)[2]

Continue Conservative Therapy

Consider:
- Epidural steroid injection
- Selective nerve root block
- Re-evaluation of pain medications[1]
- Pain management specialist evaluation
- Continue PT

Improved within 6-8 weeks?

YES

NO

Discharge From Care

Independent Consultative Opinion

Treatment Plan

Discharge From Care

Evaluate for Surgery

Mandatory Case Management

1, 2, 4 See Addendum to Care Paths

CARE PATH 2

ICD-9 CODES

722.0
722.2
722.70
722.71
728.0
739.0
953.0

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provder finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

EXHIBIT 5

CARE PATH 3

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

THORACIC SPINE SOFT TISSUE INJURY (STRAIN/SPRAIN/CONTUSION) OF THE UPPER BACK

↓

CONSERVATIVE THERAPY (up to 4 weeks)

- Provider office visits (up to 5)
- Medication[1]
- Bed rest (maximum 2-4 days)
- Increasing exercise
- Consider PT program (2-3 times a week for 2-4 weeks)[3]
- Spinal manipulation[2] (1-3 visits per week, up to 4 weeks)

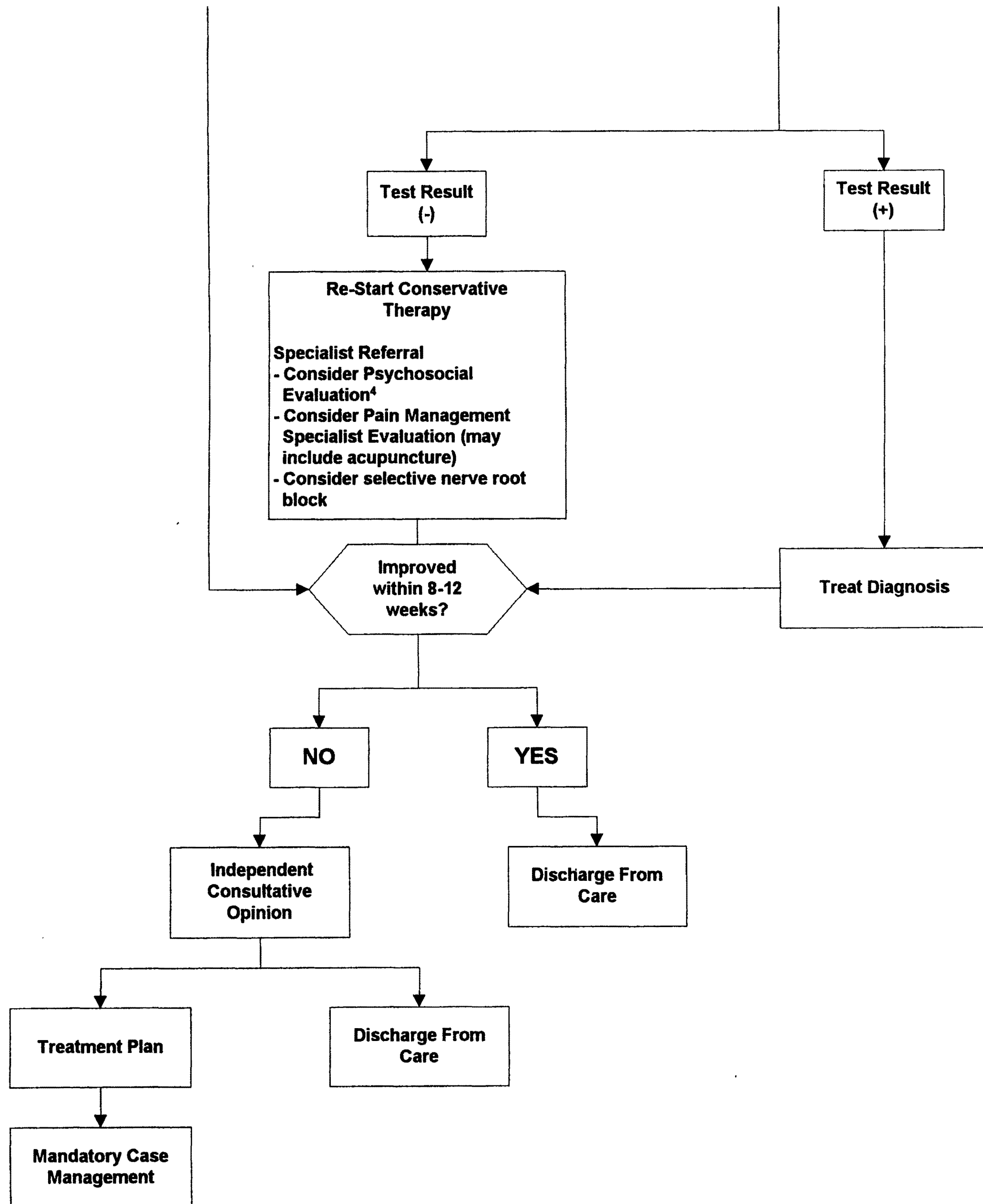
(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

4 WEEKS ↓ POST INJURY

Improvement in symptoms based on objective findings?

- **YES**
  - **Symptoms Resolved** → **Discharge from Care**
  - **Symptoms Minimally Resolved** → **Patient Compliant with Treatment Plan?**
    - **NO** → **Continue Conservative Therapy**
      - Begin or continue PT
      - Consider Specialist Referral
      - Consider Psychosocial Evaulation[4]
    - **YES** → **Continue Conservative Therapy**
      - Begin or continue PT
      - Consider Specialist Referral
      - Pain Management up to 3 visits (may include acupuncture)
- **NO**
  - **Symptoms Worse or Unresolved** → **Development of Radiculopathy?**
    - **NO** → **Diagnostic Re-evaluation**
      May include:
      - CBC
      - ESR
      - X-ray AP & Lateral
      - Bone scan
    - **YES** → Go to Care Path 4 Thoracic Spine Herniated Disc/ Radiculopathy

1, 2, 3, 4 See Addendum to Care Paths



ICD-9 CODES

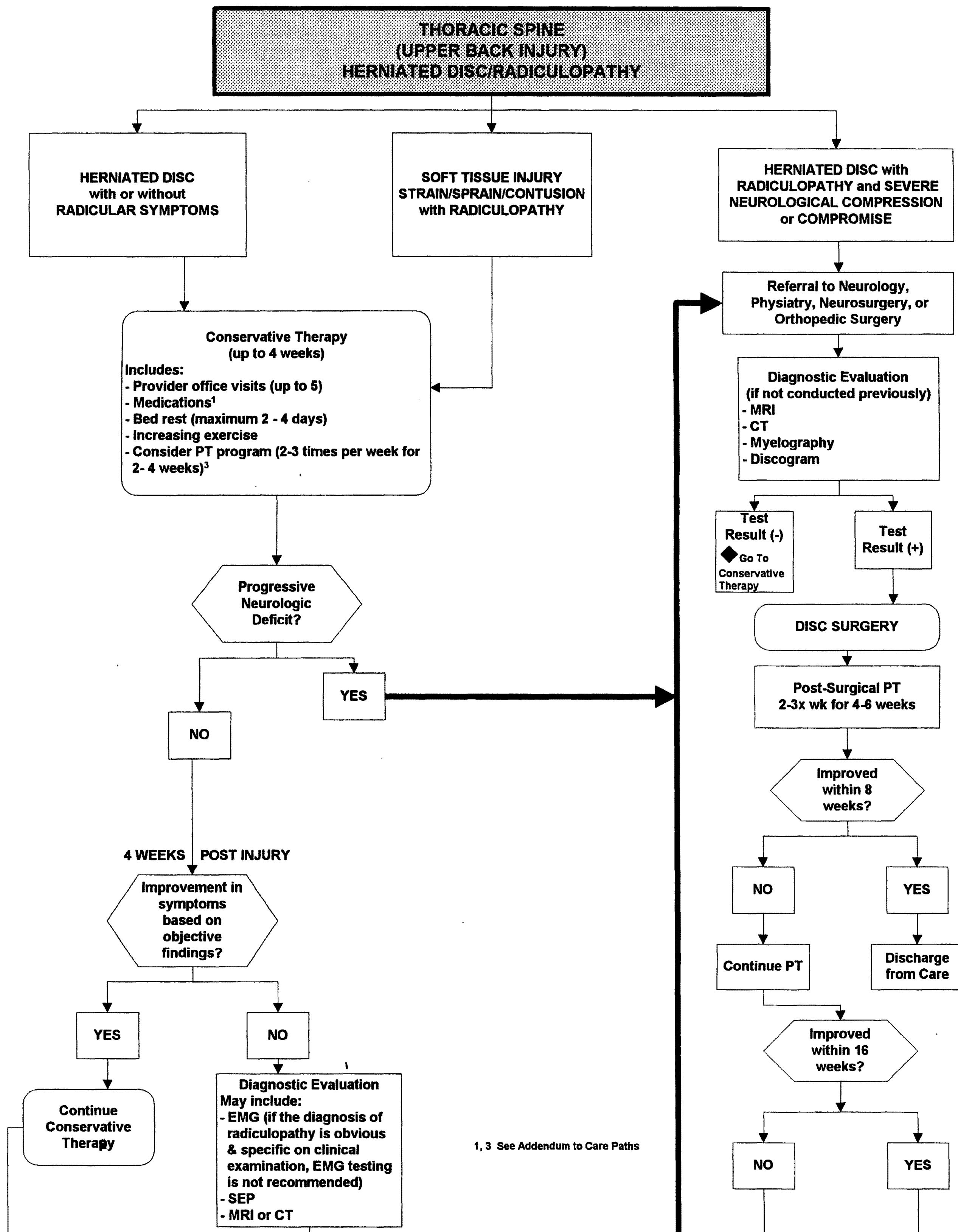
728.0
728.85
739.0
739.7
739.8
847.1
847.9
922.3
922.33
953.2

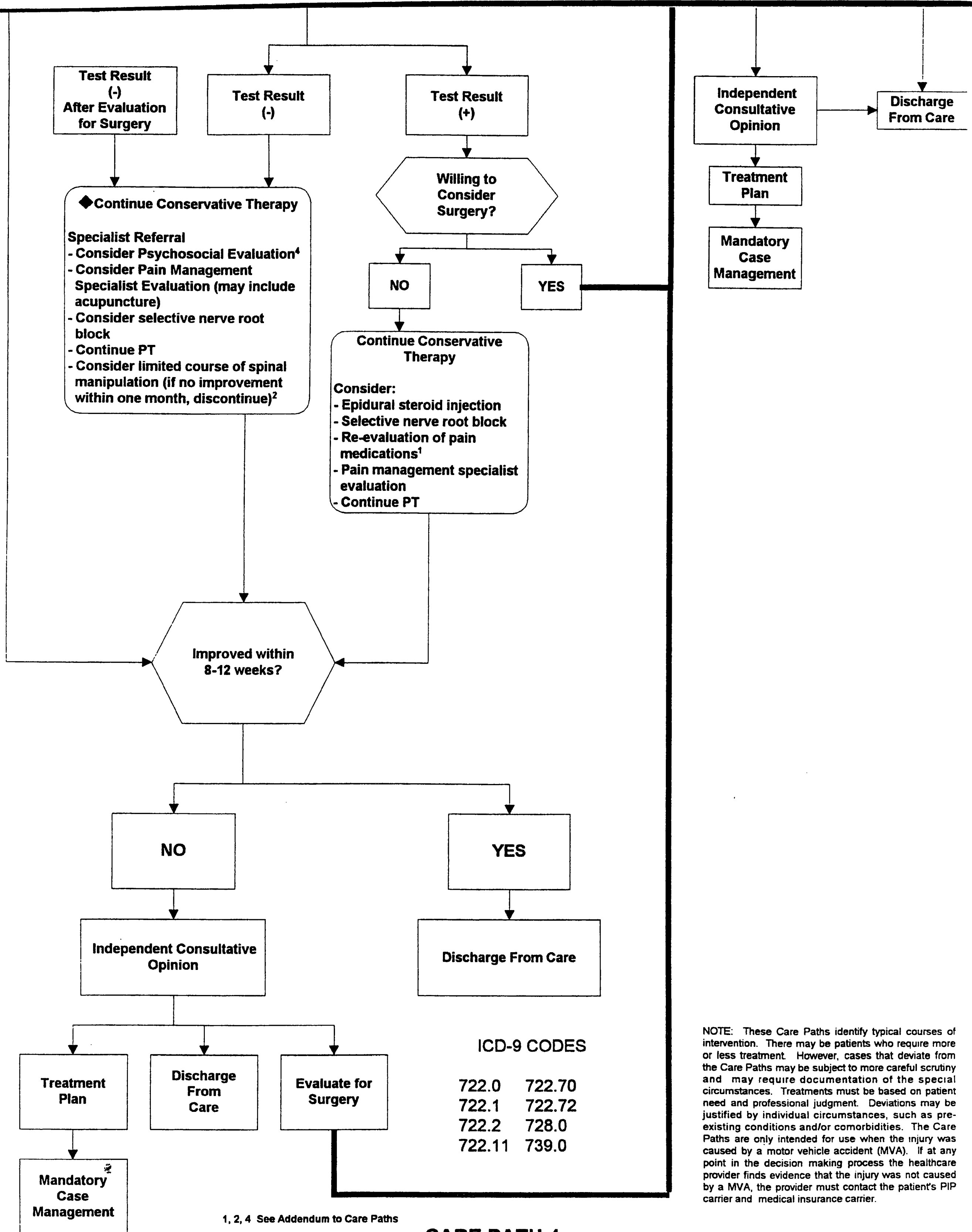
CARE PATH 3

4 See Addendum to Care Paths

EXHIBIT 6

CARE PATH 4





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CARE PATH 4

EXHIBIT 7

CARE PATH 5

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

LUMBAR-SACRAL SPINE SOFT TISSUE INJURY
(STRAIN/SPRAIN/CONTUSION) OF THE LOW BACK

↓

CONSERVATIVE THERAPY (up to 4 weeks)

- Provider office visits (up to 5)
- Medications[1]
- Bed rest (maximum 2-4 days)
- Increasing exercise
- Consider PT program (2-3 times per week for 2-4 weeks)[3]
- Spinal manipulation[2] (1-3 visits per week, up to 4 weeks)

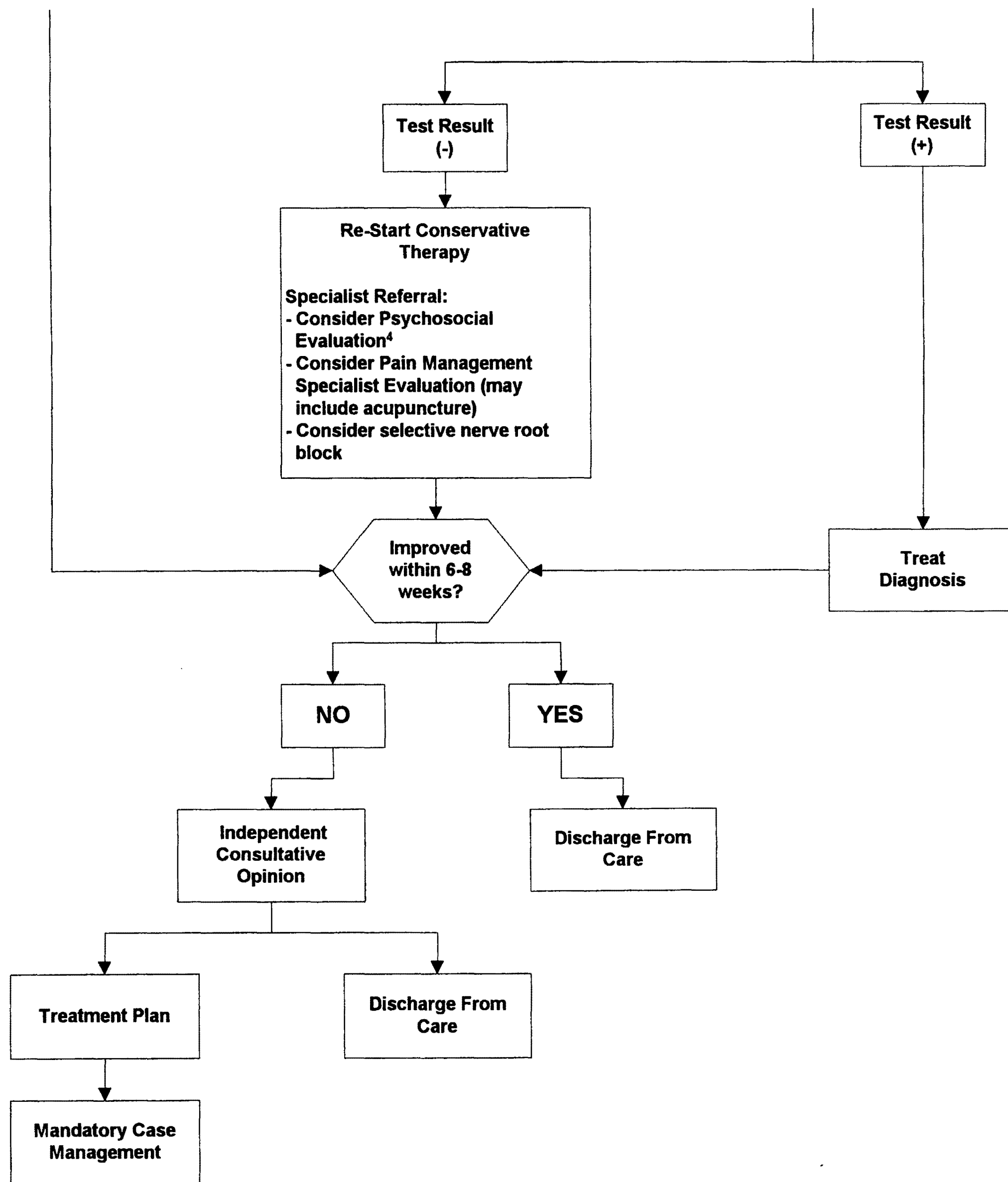
(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

↓ 4 WEEKS POST INJURY

Improvement in symptoms based on objective findings?

- **YES**
  - **Symptoms Resolved** → **Discharge from Care**
  - **Symptoms Minimally Resolved** → **Patient Compliant with Treatment Plan?**
    - **NO** → **Continue Conservative Therapy**
      - Begin or continue PT
      - Consider Specialist Referral
      - Consider Psychosocial Evaluation[4]
    - **YES** → **Continue Conservative Therapy**
      - Begin or continue PT
      - Consider Specialist Referral
      - Pain Management up to 3 visits (may include acupuncture)
- **NO**
  - **Symptoms Worse or Unresolved** → **Development of Radiculopathy?**
    - **NO** → **Diagnostic Re-evaluation**
      May include:
      - CBC
      - ESR
      - X-ray AP & Lateral
      - Bone scan
    - **YES** → Go to Care Path 6 Lumbar-Sacral Spine Herniated Disc/Radiculopathy

1, 2, 3, 4 See Addendum to Care Paths



ICD-9 CODES

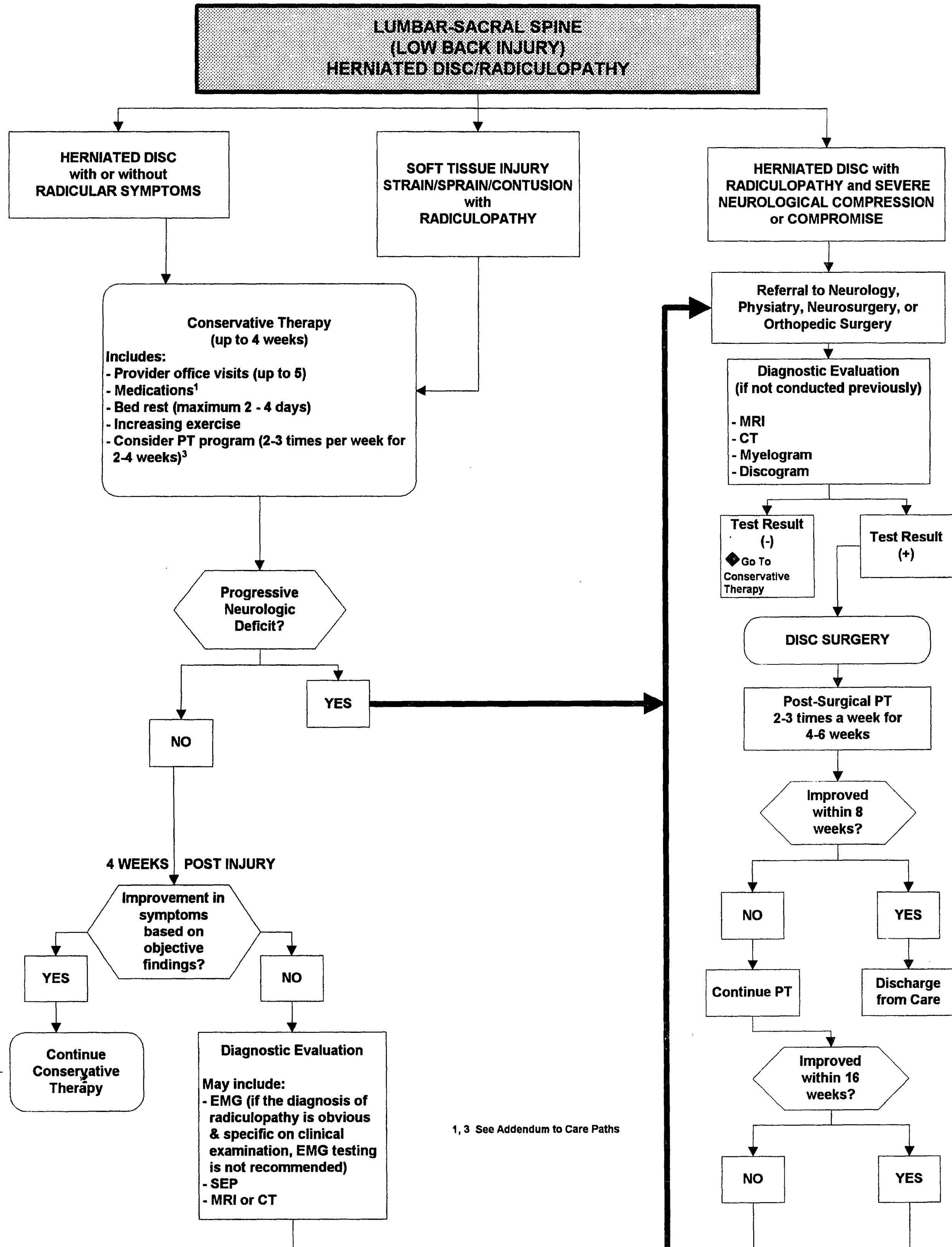
728.0	846.8
728.85	846.9
739.0	847.2
739.3	847.3
739.4	847.4
846	847.9
846.0	922.3
846.1	922.31
846.2	953.2
846.3	953.3

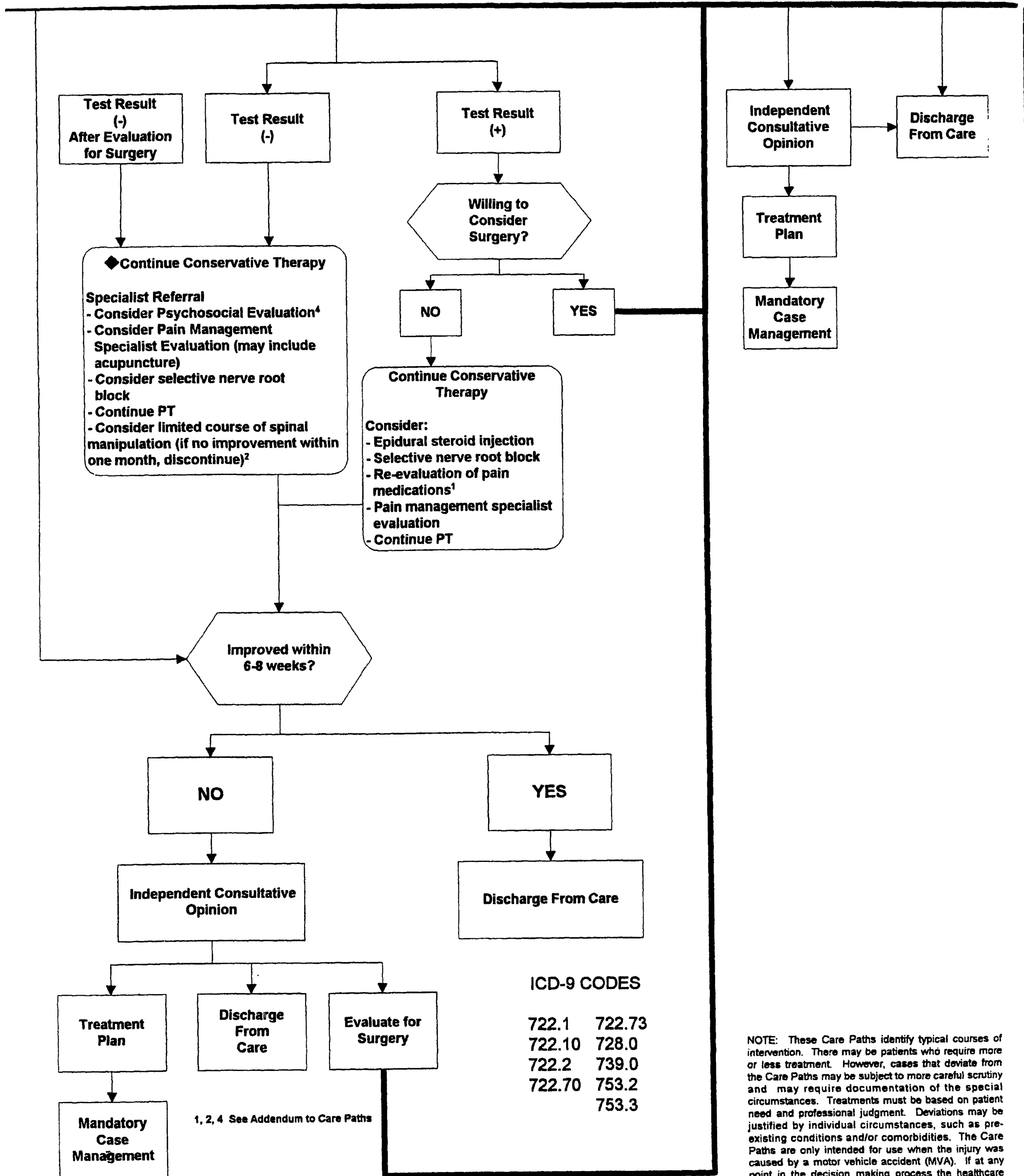
CARE PATH 5

4 See Addendum to Care Paths

EXHIBIT 8

CARE PATH 6





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CARE PATH 6

EXHIBIT 9

TREATMENT OF ACCIDENTAL INJURY
TO THE SPINE AND BACK

CARE PATH
DIAGNOSIS CODING

The following International Classification of Diseases, 9th Revision Clinical Modification—fifth edition ICD-9-CM diagnostic codes are associated with Care Path 1 through Care Path 6 for treatment of Accidental Injury to the Spine and Back and are included on each appropriate Care Path. The ICD9 codes referenced do not include codes for multiple diagnoses or comorbidity.

Care Path	Code	Description
Care Path 1	728.0	Disorders of muscle, ligament and fascia
	728.85	Spasm of muscle
	739.0	Non allopathic lesions—not elsewhere classified
	739.1	Somatic dysfunction of cervical region
	847.0	Sprains and strains of neck
	847.9	Sprains and strains of back, unspecified site
	922.3	Contusion of back
	922.31	Contusion of back, excludes interscapular region
	953.0	Injury to cervical root
Care Path 2	722.0	Displacement of cervical intervertebral disc without myelopathy
	722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
	722.70	Intervertebral disc disorder with myelopathy, unspecified region
	722.71	Intervertebral disc disorder with myelopathy, cervical region
	728.0	Disorders of muscle, ligament and fascia
	739.0	Non allopathic lesions—not elsewhere classified
	953.0	Injury to cervical root
Care Path 3	728.0	Disorders of muscle, ligament and fascia
	728.85	Spasm of muscle
	739.0	Non allopathic lesions—not elsewhere classified
	739.2	Somatic dysfunction of thoracic region
	739.8	Somatic dysfunction of rib cage
	847.1	Sprains and strains, thoracic
	847.9	Sprains and strains of back, unspecified site
	922.3	Contusion of back
	922.33	Contusion of back, interscapular region
Care Path 4	722.0	Displacement of cervical intervertebral disc without myelopathy
	722.1	Displacement of thoracic or lumbar intervertebral disc without myelopathy
	722.11	Displacement of thoracic intervertebral disc without myelopathy
	722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
	722.70	Intervertebral disc disorder with myelopathy, unspecified region
	722.72	Intervertebral disc disorder with myelopathy, thoracic region
	728.0	Disorders of muscle, ligament and fascia
	739.0	Non allopathic lesions—not elsewhere classified
Care Path 5	728.0	Disorders of muscle, ligament and fascia
	728.85	Spasm of muscle
	739.0	Non allopathic lesions—not elsewhere classified
	739.3	Somatic dysfunction of lumbar region
	739.4	Somatic dysfunction of sacral region
	846	Sprains and strains of sacroiliac region
	846.0	Sprains and strains of lumbosacral (joint) (ligament)
	846.1	Sprains and strains of sacroiliac ligament
	846.2	Sprains and strains of sacrospinatus (ligament)
	846.3	Sprains and strains of sacrotuberous (ligament)
	846.8	Sprains and strains of other specified sites of sacroiliac region
	846.9	Sprains and strains, unspecified site of sacroiliac region
	847.2	Sprains and strains, lumbar
	847.3	Sprains and strains, sacrum
	847.4	Sprains and strains, coccyx
	847.9	Sprains and strains, unspecified site of back
	922.3	Contusion of back
	922.31	Contusion of back, excludes interscapular region
	953.2	Injury to lumbar root
	953.3	Injury to sacral root
Care Path 6	722.1	Displacement of thoracic or lumbar intervertebral disc without myelopathy
	722.10	Displacement of lumbar intervertebral disc without myelopathy
	722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
	722.70	Intervertebral disc disorder with myelopathy, unspecified region
	722.73	Intervertebral disc disorder with myelopathy, lumbar region
	728.0	Disorders of muscle, ligament and fascia
	739.0	Non allopathic lesions—not elsewhere classified
	953.3	Injury to sacral root

The following ICD-9-CM supplemental classification of external causes of injury may be used in addition to the specific diagnostic codes noted above and on each Care Path:

- E 810 through E 819, selected E 820 series codes.

These codes may be used to indicate cause of injury as motor vehicle accident but should not be used without an associated diagnostic code.

EXHIBIT 10

ADDENDUM TO CARE PATHS

1. Medications

   Muscle Relaxants

   - Muscle relaxants are an option in the treatment of patients with acute neck, thoracic, and low back problems. While probably more effective than placebo, muscle relaxants have not been shown to be more effective than NSAIDs.

- No additional benefit is gained by using muscle relaxants in combination with NSAIDs over using NSAIDs alone.
- Muscle relaxants have potential side effects in 30 percent of patients. When considering the option of using relaxants, the clinician should balance the potential patient's intolerance of other agents.

Opioid Analgesics

- When used for a time-limited course, opioid analgesics are an option in the management of patients with acute neck, thoracic, and low back problems. The decision to use opioids should be guided by consideration of their potential complications relative to other options.
- Opioids appear to be more effective in relieving neck, thoracic, and low back symptoms than safer analgesics, such as acetaminophen or aspirin or other NSAIDs.
- Clinicians should be aware of the side effects of opioids, such as decreased reaction time, clouded judgment, and drowsiness, which lead to early discontinuation by as many as 35 percent of patients.
- Patients should be warned about dependence and the danger of opioids while operating heavy machinery.

Oral Steroids

- Oral steroids are not recommended for the treatment of acute neck, thoracic, or low back problems.
- A potential for severe side effects is associated with the extended use of oral steroids or steroids in high doses.

2. Who May Perform Spinal Manipulation:
   Spinal manipulation may be performed by those providers licensed or certified to perform this procedure within their scope of practice.
3. Spinal Manipulation/Chiropractic Care
   A course of spinal manipulation/chiropractic care may be considered as conservative therapy on all Care Paths. If there is no improvement within one month, then immediate reevaluation is indicated to determine appropriate further treatment and treatment options, including referral to other health care providers and/or modification of conservative therapy.
   When findings suggest progressive or severe neurologic deficits, an appropriate diagnostic assessment to rule out serious neurologic conditions is indicated in any conservative therapy.
4. Mental Health/Rehabilitation Assessment Option If Patient Has Not Responded To Treatment
   A mental health/rehabilitation assessment can be obtained if psychological/psychosocial or psychiatric distress is obvious from the history, i.e., presence of "non-organic" physical signs, repetitive back injuries, failed previous treatments, litigation or disability compensation claims, family or financial problems, apparent secondary gain, boredom and dissatisfaction with job, frequent bouts of pain, depression, alcohol and substance abuse, extreme obesity, and apparent psychiatric behavior.

EXHIBIT 11

STATE OF NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE

DECISION POINT REVIEW/PRECERTIFICATION IMPLEMENTATION REPORT

COMPANY NAME ______________________________

NAIC # __________ GROUP # __________ NO. OF COMPANIES IN GROUP__________

REPORT FOR ________________, ____________
(MONTH) (YEAR)

	Month Totals		Denial Reason				Month Total	Modified Reason			
DECISION POINT REVIEW REQUESTS	# Received	# Denied	A	B	C	D	# Modified	A	B	C	D
Treatment											
Testing											
PRECERTIFICATION REQUESTS											

	MONTH TOTAL
NUMBER OF PHYSICAL EXAMINATIONS SCHEDULED PURSUANT TO N.J.A.C. 11:3-4.7(b)(2)	
NUMBER OF PHYSICAL EXAMINATIONS COMPLETED PURSUANT TO N.J.A.C. 11:3-4.7(b)(2)	
NUMBER OF INTERNAL APPEAL REQUESTS RECEIVED	
NUMBER OF INTERNAL APPEAL REQUESTS RESULTING IN DENIAL OF INITIAL DETERMINATION	
NUMBER OF INTERNAL APPEAL REQUESTS RESULTING IN MODIFICATION OF INITIAL DETERMINATION	

Reasons for Denial /Modificiation*

A - Insufficient Information supplied by provider

B - Level of treatment not consistent with diagnosis

C - Patient has reached maximum improvement

D - Other (give brief descriptions below)

*"Medically unnecessary" is too general. Reason should be more specific

DENIED MEANS THAT THE TEST OR TREATMENT WAS FOUND NOT TO BE REIMBURSABLE UNDER PIP

MODIFIED MEANS THE TEST OR TREATMENT APPROVED WAS DIFFERENT THAN THAT REQUESTED BY THE PROVIDER

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Rewrote Exhibits 3 and 10; inserted new Exhibit 11.

SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

11:3–5.1 Purpose and scope

(a) The purpose of this subchapter is to establish procedures for the resolution of disputes concerning the payment of medical expense and other benefits provided by the personal injury protection coverage in policies of automobile insurance. This subchapter implements N.J.S.A. 39:6A–5.1 and 5.2, which provide that PIP disputes shall be resolved by binding alternate dispute resolution as provided in the policy form approved by the Commissioner. This subchapter also implements provisions of N.J.S.A. 2A:23A–1 et seq., as applicable to PIP dispute resolution.

(b) This subchapter shall apply to disputes arising under policies of private passenger automobile insurance, on either a personal lines or commercial lines policy form, that provide medical expense benefits and other benefits under personal injury protection coverage, as follows:

1. PIP benefits under a standard automobile insurance policy pursuant to N.J.S.A. 39:6A–4;

2. PIP benefits under a basic automobile insurance policy pursuant to N.J.S.A. 39:6A–3.1;

3. PIP benefits provided by the UCJF pursuant to N.J.S.A. 39:6–86.1; and

4. Additional PIP benefits provided pursuant to N.J.S.A. 39:6A–10.

(c) This subchapter shall apply to policies issued or renewed on or after March 22, 1999 in accordance with the approved policy terms.

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.

11:3–5.2 Definitions

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

"Administrator" means the dispute resolution organization designated by the Commissioner pursuant to N.J.S.A. 39:6A–5.1 and N.J.A.C. 11:3–5.3.

"Basic policy" means an automobile insurance policy issued pursuant to N.J.S.A. 39:6A–3.1 and N.J.A.C. 11:3–3.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

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