

(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:

1. Needle electromyography (needle EMG) when used in the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling. A needle EMG is not indicated in the evaluation of TMJ/D and is contraindicated in the presence of staph infection on the skin or cellulitis. This test should not normally be performed within 14 days of the traumatic event and should not be repeated where initial results are negative. Only one follow up exam is appropriate.

2. Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex Study are reimbursable when used to evaluate neuropathies and/or signs of atrophy, but not within 21 days following the traumatic injury.

3. Electroencephalogram (EEG) when used to evaluate head injuries, where there are clinically supported findings of an altered level of sensorium and/or a suspicion of seizure disorder. This test, if indicated by clinically supported findings, can be administered immediately following the insured event. When medically necessary, repeat testing is not normally conducted more than four times per year.

4. Videofluoroscopy only when used in the evaluation of hypomobility syndrome and wrist/carpal hypomobility, where there are clinically supported findings of no range or aberrant range of motion or dysmmetry of facets exist. This test should not be performed within three months following the insured event and follow up tests are not normally appropriate.

5. Magnetic resonance imaging (MRI) when used in accordance with the guidelines contained in the American College of Radiology, Appropriateness Criteria to evaluate injuries in numerous parts of the body, particularly the assessment of nerve root compression and/or motor loss. MRI is not normally performed within five days of the insured event. However, clinically supported indication of neurological gross motor deficits, incontinence or acute nerve root compression with neurologic symptoms may justify MRI testing during the acute phase immediately post injury.

6. Computer assisted tomographic studies (CT, CAT Scan) when used to evaluate injuries in numerous aspects of the body. With the exception of suspected brain injuries, CAT Scan is not normally administered immediately post injury, but may become appropriate within five days of the insured event. CAT Scan is not appropriate

for TMJ/D. Repeat CAT Scans should not be undertaken unless there is clinically supported indication of an adverse change in the patient's condition.

7. Dynatron/cyber station/cybox when used to evaluate muscle deterioration or atrophy. These tests should not be performed within 21 days of the insured event and should not be repeated if results are negative. Repeat tests are not appropriate at less than six months intervals.

8. Sonograms/ultrasound when used in the acute phase to evaluate the abdomen and pelvis for intra-abdominal bleeding. These tests are not normally used to assess joints (knee and elbow) because other tests are more appropriate. Where MRI is performed, sonogram/ultrasound are not necessary. These tests should not be used to evaluate TMJ/D. However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

(c) The terms "normal," "normally," "appropriate" and "indicated" as used above in (b), are intended to recognize that no single rule can replace the good faith educated judgment of a trained medical professional. Thus, "normal," "normally," "appropriate" and "indicated" pertain to the usual, routine, customary or common experience and conclusion, which may in unusual circumstances differ from the actual judgment or course of treatment. The unusual circumstances shall be based on clinically supported findings of a trained medical professional. The use of these terms is intended to indicate some flexibility and avoid rigidity in the application of these rules in the decision point review required in (d) below.

(d) Except as provided in (e) below, a determination to administer any of the tests in (b) above shall be subject to decision point review pursuant to N.J.A.C. 11:3-4.7.

(e) The requirements of (b) and (d) above shall not apply to diagnostic tests administered during emergency care.

#### 11:3-4.6 Medical protocols

(a) Pursuant to N.J.S.A. 39:6A-3.1 and 39:6A-4, the Commissioner designates the care paths, set forth in the subchapter Appendix incorporated herein by reference, as the standard course of medically necessary treatment, including diagnostic tests, for the identified injuries.

(b) Where the care path indicates a decision point either by a hexagon in the care path itself or by reference in the text to a second opinion, referral for a second independent consultative medical opinion, development of a treatment plan or mandatory case management, the policy shall provide for a decision point review in accordance with N.J.A.C. 11:3-4.7.

(c) Treatments that vary from the care paths shall be reimbursable only when warranted by reason of medical necessity.

(d) The care paths do not apply to treatment administered during emergency care.

#### 11:3-4.7 Decision point review

(a) Insurers shall file for approval policy forms that provide a plan for the timely review of treatment of identified injuries at decision points and for the approval of the administration of the diagnostic tests in N.J.A.C. 11:3-4.5(b).

(b) The decision point review plan shall meet the following requirements:

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) Notwithstanding the requirements of (b) above, a pre-certification plan filed and approved pursuant to N.J.A.C. 11:3-4.8 shall satisfy the requirement to have a decision point review plan.

(d) 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.

(e) 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.

#### 11:3-4.8 Pre-certification plans

(a) Insurers may file for approval policy forms that provide for a pre-certification of certain medical procedures, treatments, diagnostic tests, or other services, non-medical expenses and durable medical equipment by the insurer or its designated representative.

(b) No pre-certification requirements shall apply within 10 days of the insured event.

(c) Pre-certification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or test.

(d) An insurer that wishes to use a pre-certification plan 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 retroactively 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.

(e) The insurer shall include with its filing, the information about its pre-certification plan that will be given to consumers with new and renewal policies after the pre-certification plan is approved 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).

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

(g) 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 an approved pre-certification plan.

(h) Pre-certification plans shall avoid undue interruptions in a course of treatment.

(i) Insurers are encouraged to provide pre-certification plans that permit a treating provider to submit a comprehensive treatment plan for pre-certification so as to minimize the need for piecemeal review.

#### 11:3-4.9 Assignment of benefits

Insurers may file for approval policy forms including reasonable procedures for, or restrictions on, the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.

## 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.

**Chronic Disease**—a disease with long duration that changes little and progresses slowly. The opposite 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 indepen-

dent 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 injuries sustained in automobile accidents, e.g., physical therapy, surgery, administration of medications, etc.