SENATE, No. 938

STATE OF NEW JERSEY

INTRODUCED MARCH 14, 1996

By Senator BASSANO

AN ACT concerning automobile insurance personal injury protection benefits, amending P.L.1972, c.198 and P.L.1988. c.119 and amending and supplementing P.L.1972, c.70.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) The Legislature finds and declares that:

a. The passage of the automobile insurance "no-fault law" in 1972 resulted in the creation of personal injury protection (PIP) coverage which, among other things, was intended to provide a more efficient and cost-effective means of delivering necessary first party medical expense benefits than the more expensive fault-based tort system, thus helping to contain the cost of automobile insurance;

b. Throughout the past two decades, the cost-effectiveness of PIP medical expense benefits coverage has been eroded through a series of court decisions which have given a broad and liberal interpretation to the PIP statutes, extending these benefits to persons who were not contemplated by the Legislature to be eligible recipients of these benefits, and ruling that claims for experimental diagnostic procedures; duplicative and unnecessary treatments; and treatments which are not commonly and customarily recognized by physicians and other health care professionals as appropriate in the treatment of injured persons eligible for PIP benefits coverage are all compensable under PIP medical expense benefits coverage;

c. Treatments and procedures such as those described in subsection b. of this section too often are carried out either for the purpose of meeting the requirements of the verbal threshold, or for the purpose of increasing the settlement value of lawsuits filed for pain and suffering;

d. Recognizing the fact that New Jersey's PIP medical expense benefits coverage losses far exceed the national average and are a significant factor contributing to New Jersey's unacceptably high automobile insurance rates, the Legislature has, from time to time,

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

taken steps to contain these costs by:

(1) establishing a medical fee schedule for reimbursement of medical expense claims made under PIP benefits coverage;

(2) establishing the Division of Insurance Fraud Prevention within the Department of Insurance and requiring all automobile insurers to have detailed fraud prevention plans; and

(3) extending the time limit within which carriers are required to pay medical expense benefits claims so that carriers may investigate cases of fraudulent claims or investigate treatments which are not medically necessary;

e. The Legislature continues to find evidence that PIP medical expense benefits coverage is being abused by some individuals, including some providers of medical services, and by some claimants who over utilize the benefits, either for the purpose of meeting the requirements of the verbal threshold or for the purpose of increasing the settlement value of lawsuits filed for pain and suffering;

f. In order to address the conflict which exists between the manner in which the original no-fault law is being broadly and liberally interpreted by the courts and the Legislature's long standing objective of cost containment, the Legislature finds it necessary to ensure that PIP medical expense benefits coverage continues to be available to New Jersey residents at a reasonable price by enacting legislation which: furthers the public policy goal of cost containment; ensures that payment is not made for experimental diagnostic procedures, duplicative and unnecessary treatments, or medical expenses which are not commonly and customarily recognized by physicians and other health care professionals as appropriate in the treatment of injured persons eligible for PIP benefits coverage; and which ensures that PIP medical expense benefits are not extended to persons who were not contemplated to be eligible to collect those benefits under the original no-fault law; and

g. To that end, the Legislature declares that it is in the public interest to:

(1) express clearly its intent that all cost containment measures be applied vigorously and responsibly to the no-fault law;

(2) authorize the creation of independent peer review organizations (PROs) to determine the medical necessity and appropriateness of treatments promptly and fairly when there is a dispute between the insurer and the provider or claimant, establish the presumption that the determination of a PRO is correct when reviewed by a court of competent jurisdiction, and establish the standard for overturning the decision of a PRO to be a "preponderance of evidence" showing that the determination of a PRO was erroneous; and

(3) modify the current arbitration process for PIP benefits so that only specified disputes, which arise with respect to claims under PIP medical expense benefits coverage, will be arbitrated according to

New Jersey law and in the most efficient and cost effective manner consistent with the Rules Governing the Courts of the State of New Jersey, and so that disputes concerning medical necessity or appropriateness of treatment are resolved through the PRO process established pursuant to the provisions of this act.

2. (New section) As used in sections 2 through 6 of this act:

"Commissioner" means the Commissioner of Insurance;

"Insurer" means an insurer or group of affiliated companies admitted or authorized to transact the business of private passenger automobile insurance in this State and the Unsatisfied Claim and Judgment Fund;

"Peer review organization" or "PRO" means a group of health care professionals licensed in New Jersey, or any peer review organization with which the Federal Health Care Financing Administration or the State contracts for medical review of Medicare or medical assistance services approved by the commissioner, or any independent health care review company approved by the commissioner, to engage in unbiased peer review for the purpose of determining the medical necessity or appropriateness of treatment, services or durable medical goods provided to a person injured in an automobile accident.

"Provider of health care services" or "provider" means and shall include, but not be limited to: (1) a health service corporation, a hospital service corporation or medical service corporation; (2) a hospital or health care facility under contract with a health service corporation to provide health care services or supplies to persons who become subscribers under contracts with the health service corporation; (3) a hospital or health care facility which is maintained by a state or any of its political subdivisions; (4) a hospital or health care facility licensed by the Department of Health; (5) other hospitals or health care facilities, as designated by the Department of Health to provide health care services; (6) a registered nursing home providing convalescent care; (7) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital; (8) hospitals or other health care facilities located in other states, which are subject to the supervision of those states, which if located in this State would be eligible to be licensed or designated by the Department of Health; (9) nonprofit hospital, medical or health service plans of other states approved by the commissioner; (10) physicians licensed to practice medicine and surgery; (11) licensed chiropractors; (12) licensed dentists; (13) licensed optometrists; (14) licensed pharmacists; (15) licensed chiropodists; (16) registered bio-analytical laboratories; (17) licensed psychologists; (18) registered physical therapists; (19) certified nurse-midwives; (20) registered professional nurses; (21) licensed health maintenance organizations; and (22) providers of other similar health care services or supplies as are approved by the

commissioner.

3. (New section) a. The commissioner shall approve an application to act as a PRO if the commissioner determines that the applicant complies with the standards of performance which the commissioner, after consultation with the Commissioner of Health, establishes as reasonable and necessary to provide an impartial review of the medical necessity or appropriateness of treatments, health care services or durable medical goods for which medical expense benefits are being provided under personal injury protection coverage. The standards established by the commissioner shall include procedures necessary to assure the independence of the review process, and shall include standards with respect to experience, licensure, fees and confidentiality.

b. To be considered for approval as a PRO pursuant to subsection a. of this section, an applicant shall:

(1) have a sufficient number of health care providers, by specialty, to perform the medical reviews;

(2) use only New Jersey licensed health care providers to perform the medical reviews;

(3) provide satisfactory evidence that the confidentiality of individual medical records will be maintained;

(4) have procedures in effect to guarantee the fair and open exchange of information and records related to reviews between the provider and the PRO;

(5) not be owned by or controlled by an insurer. As used in this paragraph, "controlled by" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless that power is the result of an official position with or corporate office held by the person; and

(6) meet such other requirements as the commissioner may deem relevant.

c. An approval shall be granted to a PRO for a period of five years. An approved PRO shall undergo periodic examinations in accordance with the standards established by the commissioner pursuant to subsection a. and b. of this section. If, at any time the commissioner determines that the review procedures of an approved PRO are not being carried out in an impartial and independent manner, the commissioner may suspend or revoke the PRO's authority to perform reviews. If the commissioner determines that a substantially disproportionate number of reviews are being requested by an insurer or if an insurer is requesting one particular PRO to perform a substantially disproportionate number of reviews so as to give the appearance that the reviews are not being carried out in an impartial

and independent manner, the commissioner may order the insurer to reduce the number of cases being referred for review by any PRO or may order the insurer to reduce the number of claims referred by the insurer to a particular PRO, as applicable.

d. An approved PRO shall submit an annual activity report to the commissioner, in a form approved by the commissioner, by January 31 of each year and shall establish audit procedures, which shall be approved by the commissioner, to ensure compliance with statutory and regulatory requirements.

4. (New section) Insurers may contract with an approved peer review organization for the independent review of treatments, health care services, or durable medical goods provided to any person injured as a result of an automobile accident. The independent review shall be for the purpose of confirming that treatments, health care services, or durable medical goods conform to the professional standards of performance and are medically necessary and appropriate. When appropriate in the context of its review of challenged treatments, health care services or durable medical goods, a PRO may request and review a provider's projected treatment plan.

If in the course of its review, a PRO questions whether the treatments, health care services, or durable medical goods relating to an injury for which reimbursement is being sought are causally related to an insured event, the PRO shall notify the insurer of its recommendation concerning any issue of causality. Such a recommendation by a PRO shall not be determinative. An insurer shall pursue denial of payment on the grounds that the treatments, health care services or durable medical goods relating to an injury for which reimbursement is being sought are not causally related to an insured event in accordance with the provisions of section 13 of P.L.1972, c.70 (C.39:6A-13).

5. (New section) a. A PRO shall utilize in its independent review of a challenged claim, a provider of health care services licensed in New Jersey in the same profession or specialty as the provider whose services are subject to review, or who is determined relative to the providing of a durable medical good, the use of which is subject to review. A PRO may review the medical necessity or appropriateness of the use of the durable medical good regardless of whether the durable medical good was prescribed by a provider.

b. A PRO shall establish and utilize written review procedures, which shall be filed with the commissioner. A PRO shall conduct its reviews in accordance with the latest medical protocols generally accepted within the health care professions.

c. Every PRO determination shall be in writing in accordance with regulations adopted by the commissioner, citing specific findings based

upon the clinical criteria and consistent with the written review procedures on file with the commissioner.

d. Compensation for the services of a PRO shall be in accordance with regulations promulgated by the commissioner and shall not be based on a percentage or contingency fee basis.

6. (New section) a. Any referral by an insurer to a PRO shall be made within 90 days of the insurer's receipt of a bill for treatment, health care services, or durable medical goods. An insurer shall not be required to pay the provider for services subject to a PRO review until such time as there is a final determination by the PRO, except as otherwise provided in subsection g. of this section. An insurer shall notify a provider or injured person, as appropriate, in writing, by certified mail, when a PRO referral is made and that the insurer is not required to pay the provider or injured person, as appropriate, who is the subject of the referral until a determination has been made by the PRO. An injured person shall not be liable for payment for any treatments, health care services, or durable medical goods that are subject to the PRO review except as provided in paragraph (2) of subsection f. of this section. A provider whose treatments, health care services or durable medical goods are the subject of a PRO review may request, and shall be granted, an opportunity to discuss his treatments or treatment plans with the reviewer.

b. A PRO shall complete its review and make a determination within 30 days of receipt of all requested information from the provider. An insurer shall be required to notify the provider and act on the PRO's initial determination within seven business days of receipt of that determination.

c. Upon the request of the PRO performing a review, a provider whose services are the subject of review shall furnish a written report of the history, condition, treatment dates and costs of treatment of the injured person, and shall produce and permit the inspection and copying of the records regarding the history, condition, treatment dates and costs of treatment and shall submit all necessary documentation to establish that a challenged treatment, health care service, or durable medical good is commonly and customarily recognized throughout the health care professions as appropriate in the treatment of the particular injury for which it was ordered. The insurer shall pay all reasonable costs connected therewith. In any dispute regarding discovery of facts about the injured person's history, condition, treatment dates and costs of treatment, or regarding a mental or physical examination of the injured person, the insurer or injured person may petition a court of competent jurisdiction for an order resolving the dispute. The order may be entered on motion for good cause shown giving notice to all persons having an interest therein. The court may protect against annoyance, embarrassment or

oppression and may, as justice requires, enter an order compelling or refusing discovery, or specifying conditions of that discovery; the court may further order the payment of costs and expenses of the proceeding, as justice requires.

d. An insurer, provider, or injured person may request a reconsideration of a PRO's initial determination if the request for reconsideration is made within 30 days of notification of the PRO's initial determination. A reconsideration shall be conducted by a PRO other than the PRO that conducted the initial review. A PRO reviewing the decision rendered by the initial PRO shall afford an insurer, provider or injured person involved an opportunity to discuss the case with the reviewer and to file any additional information which was not available at the time of the initial PRO review. The PRO performing the reconsideration may base its determination on information from the initial determination, other information in the records, or additional evidence submitted by the requesting party and shall complete the reconsideration within 30 days of receipt of all requested information, unless otherwise agreed to by all parties. An insurer shall be required to notify the provider and to act upon the final determination of the PRO conducting the reconsideration review within seven business days of receipt of that determination. The costs of the reconsideration shall be borne by the insurer.

e. When appropriate, a PRO may request an injured person to submit to a mental or physical examination by an independent practitioner, selected by the PRO, who is: not affiliated with either the PRO or the insurer; licensed in the same profession or specialty as the provider whose services are the subject of review; and located within a reasonable proximity to the injured person's residence. The injured person shall provide or make available to the independent practitioner any pertinent medical records or medical history that the independent practitioner deems necessary to the examination. The costs of any such examination requested by a PRO shall be borne by the insurer. Insurers providing personal injury protection medical expense benefits coverage are authorized to include reasonable provisions in their policies requiring those claiming personal injury protection medical expense benefits coverage to submit to mental or physical examinations requested by a PRO pursuant to this subsection. Failure to submit to a mental or physical examination requested by a PRO pursuant to this subsection shall subject the injured person to limitations in coverage as specified in the policy form for personal injury protection medical expense benefits coverage as approved for use by the commissioner. In the case of the Unsatisfied Claim and Judgment Fund, the commissioner may promulgate rules governing the failure of an injured person to submit to a mental or physical examination requested pursuant to this subsection.

f. (1) If a PRO determines that the treatment or service was

medically necessary or appropriate, the insurer shall pay the provider or claimant, where appropriate, the outstanding amount. If the determination occurs later than 90 days following receipt of the bill, the insurer shall pay the provider the outstanding amount plus interest at the rate established for post-judgment interest by the Rules Governing the Courts of the State of New Jersey. Interest shall accrue on overdue payments beginning the 91st day following the insurer's receipt of the provider's bill.

(2) If a PRO determines that a health care provider provided unnecessary medical treatments, health care services or durable medical goods, or that inappropriate treatments, health care services or durable medical goods were provided, the provider shall not be reimbursed by the insurer for any unnecessary or inappropriate treatment, service or durable medical good and shall be prohibited from requiring the injured person to pay amounts so billed. If an injured person purchases a durable medical good without prescription, and a PRO determines, upon review, that the durable medical good is unnecessary or inappropriate, the claim for that durable medical good shall not be reimbursable.

(3) If the provider or injured person has collected a payment for a treatment, medical service or durable medical good, the provider or injured person shall return the amount paid, plus interest as prescribed by the Rules Governing the Courts of the State of New Jersey, to the insurer within 30 days of the determination of the PRO pursuant to paragraph (2) of this subsection. Interest on that payment shall accrue from the receipt of payment by the provider. The failure of the provider to return the payment shall not obligate the injured person to assume responsibility for the payment for that treatment, health care service or durable medical good.

g. Within 30 days of the date of notification of an initial or final determination by a PRO, an insurer, provider or injured person may seek review of the dispute by the Superior Court, Law Division. The determination of the PRO shall be presumed correct and shall be admissible as evidence at trial upon the request of any party involved in the PRO's review. A presumption under this section may be rebutted in an appropriate action only by a preponderance of the evidence presented to the court showing that the PRO determination was erroneous. The insurer shall not be required to pay any amount in dispute until such time as the judicial proceeding is concluded. A provider of health care services shall not bill an injured person to which the provisions of this section apply for any medical treatment, health care services, or durable medical goods which are the subject of a judicial proceeding.

7. Section 7 of P.L.1972, c.198 (C.39:6-86.1) is amended to read as follows:

7. When any person qualified to receive payments under the provisions of the "Unsatisfied Claim and Judgment Fund Law" suffers bodily injury or death as a pedestrian, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), caused by a motor vehicle, including an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), and a motorcycle, or by an object propelled therefrom, or arising out of an accident while occupying, entering into, alighting from, or using an automobile, registered or principally garaged in this State for which personal injury protection benefits under the "New Jersey Automobile Reparation Reform Act," P.L.1972, c.70 (C.39:6A-1 et seq.), or section 19 of P.L.1983, c.362 (C.17:28-1.3), would be payable to such person if personal injury protection coverage were in force and the damages resulting from such accident or death are not satisfied due to the personal injury protection coverage not being in effect with respect to such accident, then in such event the Unsatisfied Claim and Judgment Fund shall provide, under the following conditions, the following benefits:

a. Medical **[**expenses**]** expense benefits. Payment of all reasonable and necessary medical expense benefits in an amount not exceeding $250,000 per person per accident. Medical expense benefits payable pursuant to the provisions of this subsection shall be considered reasonable and necessary only if consistent with the Legislature's intent as stated in sections 1 through 6 of P.L. , c. (C.) (pending in the Legislature as this bill). In the event of death, payment shall be made to the estate of the decedent.

Medical expense benefit payments shall be subject to a deductible of $250.00 on account of injury in any one accident and a copayment of 20% of any benefits payable between $250.00 and $5,000.00.

b. Income continuation benefits. The payment of the loss of income of an income producer as a result of bodily injury disability, subject to a maximum weekly payment of $100.00. Such sums shall be payable during the life of the injured person and shall be subject to an amount or limit of $5,200.00, on account of injury to any one person in any one accident, except that in no case shall income continuation benefits exceed the net income normally earned during the period in which the benefits are payable.

c. Essential services benefits. Payment of essential services benefits to an injured person shall be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family and members of the family residing in the household, subject to an amount or limit of $12.00 per day. Such benefits shall be payable during the life of the injured person and shall be subject to an amount or limit of $4,380.00, on account of injury to any one person in any one accident.

d. Death benefits. In the event of the death of an income producer

as a result of injuries sustained in an accident entitling such person to benefits under this section, the maximum amount of benefits which could have been paid to the income producer, but for his death, under subsection b. of this section shall be paid to the surviving spouse, or in the event there is no surviving spouse, then to the surviving children, and in the event there are no surviving spouse or surviving children, then to the estate of the income producer.

In the event of the death of one performing essential services as a result of injuries sustained in an accident entitling such person to benefits under subsection c. of this section, the maximum amount of benefits which could have been paid such person, under subsection c., shall be paid to the person incurring the expense of providing such essential services.

e. Funeral expenses benefits. All reasonable funeral, burial and cremation expenses, subject to a maximum benefit of $1,000.00, on account of the death to any one person in any one accident shall be payable to decedent's estate.

Provided, however, that no benefits shall be paid under this section unless the person applying for benefits has demonstrated that he is not disqualified by reason of the provisions of subsection (a), (c), (d) or (l) of section 10 of P.L.1952, c.174 (C.39:6-70), or any other provision of law.

(cf: P.L.1990, c.8, s.101)

8. Section 4 of P.L.1972, c.70 (C.39:6A-4) is amended to read as follows:

4. Every automobile liability insurance policy, issued or renewed on or after January 1, 1991, insuring an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2) against loss resulting from liability imposed by law for bodily injury, death and property damage sustained by any person arising out of ownership, operation, maintenance or use of an automobile shall provide personal injury protection coverage, as defined hereinbelow, under provisions approved by the Commissioner of Insurance, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled <u>unintentionally</u> by or from an automobile, to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured, and to pedestrians, sustaining bodily injury caused by the named insured's automobile or struck by an object propelled <u>unintentionally</u> by or from such automobile.

"Personal injury protection coverage" means and includes:

a. Medical expense benefits. Payment of reasonable medical expenses in an amount not to exceed $250,000 per person per accident. Medical expenses payable pursuant to the provisions of this subsection shall be considered reasonable and necessary only if consistent with the Legislature's intent as stated in sections 1 through 6 of P.L. , c. (C.) (pending in the Legislature as this bill). In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of personal injury to any one person in any one accident, such excess shall be paid by the insurer in consultation with the Unsatisfied Claim and Judgment Fund Board and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1).

b. Income continuation benefits. The payment of the loss of income of an income producer as a result of bodily injury disability, subject to a maximum weekly payment of $100.00. Such sum shall be payable during the life of the injured person and shall be subject to an amount or limit of $5,200.00, on account of injury to any one person in any one accident, except that in no case shall income continuation benefits exceed the net income normally earned during the period in which the benefits are payable.

c. Essential services benefits. Payment of essential services benefits to an injured person shall be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family and members of the family residing in the household, subject to an amount or limit of $12.00 per day. Such benefits shall be payable during the life of the injured person and shall be subject to an amount or limit of $4,380.00, on account of injury to any one person in any one accident.

d. Death benefits. In the event of the death of an income producer as a result of injuries sustained in an accident entitling such person to benefits under this section, the maximum amount of benefits which could have been paid to the income producer, but for his death, under subsection b. of this section shall be paid to the surviving spouse, or in the event there is no surviving spouse, then to the surviving children, and in the event there are no surviving spouse or surviving children, then to the estate of the income producer.

In the event of the death of one performing essential services as a result of injuries sustained in an accident entitling such person to benefits under subsection c. of this section, the maximum amount of benefits which could have been paid such person, under subsection c., shall be paid to the person incurring the expense of providing such essential services.

e. Funeral expenses benefits. All reasonable funeral, burial and cremation expenses, subject to a maximum benefit of $1,000.00, on

account of the death of any one person in any one accident shall be payable to decedent's estate.

Benefits payable under this section shall:

(1) Be subject to any option elected by the policyholder pursuant to section 13 of P.L.1983, c.362 (C.10:6A-4.3);

(2) Not be assignable, except to a provider of service benefits under this section, nor subject to levy, execution, attachment or other process for satisfaction of debts.

Medical expense benefit payments shall be subject to a deductible of $250.00 on account of injury in any one accident and a copayment of 20% of any benefits payable between $250.00 and $5,000.00.

No insurer or health provider providing benefits to an insured shall have a right of subrogation for the amount of benefits paid pursuant to any deductible or copayment under this section.

(cf: P.L.1990, c.8, s.4)

9. Section 10 of P.L.1988, c.119 (C.39:6A-4.6) is amended to read as follows:

10. The Commissioner of Insurance shall, within 90 days after the effective date of P.L.1990, c.8 (C.17:33B-1 et al.), promulgate medical fee schedules on a regional basis for the reimbursement of health care providers providing services or equipment for medical expense benefits for which payment is to be made by an automobile insurer under personal injury protection coverage pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or by an insurer under medical expense benefits coverage pursuant to section 2 of P.L.1991, c.154 (C.17:28-1.6). These fee schedules shall be promulgated on the basis of the type of service provided, and shall incorporate the reasonable and prevailing fees of 75% of the practitioners within the region. If, in the case of a specialist provider, there are fewer than 50 specialists within a region, the fee schedule shall incorporate the reasonable and prevailing fees of the specialist providers on a Statewide basis. These schedules shall be reviewed biannually by the commissioner<u>, and the commissioner may amend the fee schedules as he deems necessary to maximize cost containment in medical expense payments made pursuant to personal injury protection benefits coverages</u>.

No health care provider may demand or request any payment from any person in excess of those permitted by the medical fee schedules established pursuant to this section, nor shall any person be liable to any health care provider for any amount of money which results from the charging of fees in excess of those permitted by the medical fee schedules established pursuant to this section.

(cf: P.L.1991, c.154, s.6)

10. Section 5 of P.L.1972, c.70 (C.39:6A-5) is amended to read as follows:

5. a. An insurer may require written notice to be given as soon as practicable after an accident involving an automobile with respect to which the policy affords personal injury protection coverage benefits pursuant to this act. In the case of claims for medical expense benefits, written notice shall be provided to the insurer by the treating medical provider no later than 21 days following the commencement of treatment. Notification required under this section shall be made in accordance with regulations adopted by the Commissioner of Insurance and on a form prescribed by the Commissioner of Insurance. Within a reasonable time after receiving notification required pursuant to this act, the insurer shall confirm to the treating medical provider that its policy affords the claimant personal injury protection coverage benefits as required by section 5 of P.L.1972, c.70 (C.39:6A-5).

b. For the purposes of this section, notification shall be deemed to be met if a treating medical provider submits a bill or invoice to the insurer for reimbursement of services within 21 days of the commencement of treatment.

c. In the event that notification is not made by the treating medical provider within 21 days following the commencement of treatment, the insurer shall reserve the right to deny, in accordance with regulations established by the Commissioner of Insurance, payment of the claim and the treating medical provider shall be prohibited from seeking any payment directly from the insured. In establishing the standards for denial of payment, the Commissioner of Insurance shall consider the length of delay in notification, the severity of the treating medical provider's failure to comply with the notification provisions of this act based upon the potential adverse impact to the public and whether or not the provider has engaged in a pattern of noncompliance with the notification provisions of this act. In establishing the regulations necessary to effectuate the purposes of this subsection, the Commissioner of Insurance shall define specific instances where the sanctions permitted pursuant to this subsection shall not apply. Such instances may include, but not be limited to, a treating medical provider's failure to provide notification to the insurer as required by this act due to the insured's medical condition during the time period within which notification is required.

d. A medical provider who fails to notify the insurer within 21 days and whose claim for payment has been denied by the insurer pursuant to the standards established by the Commissioner of Insurance may, in the discretion of a judge of the Superior Court, be permitted to refile such claim provided that the insurer has not been substantially prejudiced thereby. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to notify the insurer within the period of time prescribed by this act.

e. For the purposes of this section, "treating medical provider" shall mean any licensee of the State of New Jersey whose services are reimbursable under personal injury protection coverage, including but not limited to persons licensed to practice medicine and surgery, psychology, chiropractic, or such other professions as the Commissioner of Insurance determines pursuant to regulation, or other licensees similarly licensed in other states and nations, or the practitioner of any religious method of healing, or any general hospital, mental hospital, convalescent home, nursing home or any other institution, whether operated for profit or not, which maintains or operates facilities for health care, whose services are compensated under personal injury protection insurance proceeds.

f. In instances when multiple treating medical providers render services in connection with emergency care, the Commissioner of Insurance shall designate, through regulation, a process whereby notification by one treating medical provider to the insurer shall be deemed to meet the notification requirements of all the treating medical providers who render services in connection with emergency care.

g. Personal injury protection coverage benefits shall be overdue if not paid within 60 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer; provided, however, that any payment shall not be deemed overdue where, within 60 days of receipt of notice of the claim, the insurer notifies the claimant or his representative in writing of the denial of the claim or the need for additional time, not to exceed 45 days, to investigate the claim, and states the reasons therefor. The written notice stating the need for additional time to investigate the claim shall set forth the number of the insurance policy against which the claim is made, the claim number, the address of the office handling the claim and a telephone number, which is toll free or can be called collect, or is within the claimant's area code. For the purpose of determining interest charges in the event the injured party prevails in a subsequent proceeding where an insurer has elected a 45-day extension pursuant to this subsection, payment shall be considered overdue at the expiration of the 45-day period or, if the injured person was required to provide additional information to the insurer, within 10 business days following receipt by the insurer of all the information requested by it, whichever is later. Notwithstanding the foregoing, an insurer may refer a claim or bill, as appropriate, to a peer review organization pursuant to section 6 of P.L. , c.

(C.) (pending in the Legislature as this bill), no later than 90 days following the receipt of the claim or bill, and denial or reimbursement of the claim shall be made in accordance with the provisions of that section.

For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money. Interest shall accrue beginning the 91st day after the insurer receives written notice of a covered loss.

h. **[**All overdue payments shall bear interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.**]** All automobile insurers and the Unsatisfied Claim and Judgment Fund shall provide any claimant with the option of submitting a dispute **[**under this section**]** , arising pursuant only to the following provisions, to binding arbitration: subsections b., c., d. and e. of section 4 of P.L.1972, c.70 (39:6A-4); subsections b., c., d., and e. of section 7 of P.L.1972, c.198 (39:6-86.1); additional first party coverage benefits required to be offered pursuant to section 10 of P.L.1972, c.70 (39:6A-10), or disputes concerning whether a submitted charge or fee is in conformance with the provisions of section 10 of P.L.1988, c.119 (C.39:6A-4.6). Arbitration proceedings shall be administered and subject to procedures established by the American Arbitration Association and shall be approved by the commissioner. Arbitrators shall render their decisions in conformance with New Jersey law and consistent with the Legislature's intent as stated in section 1 of P.L. , c. (C.) (pending in the Legislature as this bill). If the claimant prevails in the arbitration proceedings, the insurer shall pay all the costs of the proceedings, including reasonable attorney's fees, to be determined in accordance with **[**a schedule of hourly rates for services performed, to be prescribed by the Supreme Court**]** the Rules Governing the Courts of the State of New Jersey and in accordance with the Rules of Professional Conduct. Disputes concerning the determination of the medical necessity or appropriateness of treatments, health care services or durable medical goods and disputes concerning whether a treatment, health care service or durable medical good relating to an injury for which reimbursement is being sought is causually related to an insured event, shall not be subject to binding arbitration.

(cf: P.L.1995, c.407, s.1)

11. Section 13 of P.L.1972, c.70 (C.39:6A-13) is amended to read as follows:

13. The following apply to personal injury protection coverage benefits:

a. Every employer shall, if a request is made by an insurer or the Unsatisfied Claim and Judgment Fund providing personal injury protection benefits under this act against whom a claim has been made, furnish forthwith, in a form approved by the Commissioner of Insurance, a signed statement of the lost earnings since the date of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

b. Every physician, hospital, clinic or other medical institution providing, before and after the bodily injury upon which a claim for personal injury protection benefits is based, any products, services or accommodations in relation to such bodily injury or any other injury, or in relation to a condition claimed to be connected with such bodily injury or any other injury, shall, if requested to do so by the insurer or the Unsatisfied Claim and Judgment Fund against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates and costs of such treatment of the injured person, and produce forthwith and permit the inspection and copying of his or its records regarding such history, condition, treatment dates and costs of treatment. The person requesting such records shall pay all reasonable costs connected therewith.

c. The injured person shall be furnished upon demand a copy of all information obtained by the insurer or the Unsatisfied Claim and Judgment Fund under the provisions of this section, and shall pay a reasonable charge, if required by the insurer and the Unsatisfied Claim and Judgment Fund.

d. **[**Whenever**]** Except for medical expense benefits provided pursuant to subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4), subsection a. of section 7 of P.L.1972, c.198 (C.39:6-86.1) and additional first party medical expense benefits coverage provided pursuant to section 10 of P.L.1972, c.70 (C.39:6A-10), if there is no dispute concerning whether the treatments, health care services or durable medical goods related to an injury for which reimbursement is being sought are causally related to an insured event, whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection benefits, such person shall, upon request of an insurer or the Unsatisfied Claim and Judgment Fund submit to mental or physical examination **[**by a physician or physicians , or chiropractor or chiropractors. Only a licensed chiropractor may determine the clinical need for further chiropractic treatment by performing a chiropractic examination and this determination shall not depend solely upon a review of the treating

chiropractor patient records in cases of denial of benefits**]** conducted by a provider of health care services licensed in this State in the same profession or specialty as the provider of health care services whose services are subject to review under this section and who is located within a reasonable proximity to the injured person's residence. The injured person shall provide or make available to the provider any pertinent medical records or medical history that the provider deems necessary to the examination. The costs of any examinations requested by an insurer or the Unsatisfied Claim and Judgment Fund shall be borne entirely by whomever makes such request. Such examination shall be conducted within the municipality of residence of the injured person. If there is no qualified **[**physician or chiropractor**]** provider of health care services to conduct the examination within the municipality of residence of the injured person, then such examination shall be conducted in an area of the closest proximity to the injured person's residence. Personal injury protection insurers are authorized to include reasonable provisions in personal injury protection coverage policies **[**for mental and physical examinations of**]** requiring those claiming personal injury protection coverage benefits to submit to mental or physical examinations as requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section. Failure to submit to a mental or physical examination requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section shall subject the injured person to certain limitations in coverage as specified in the policy form for personal injury protection coverage benefits approved for use by the commissioner. In the case of the Unsatisfied Claim and Judgment Fund, the commissioner may adopt rules governing the failure of an injured person to submit to a mental or physical examination as required pursuant to the provisions of this section.

e. If requested by the person examined, a party causing an examination to be made, shall deliver to him a copy of every written report concerning the examination rendered by an examining **[**physician or chiropractor**]** provider of health care services, at least one of which reports must set out his findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled upon request to receive from the person examined every written report available to him, or his representative, concerning any examination, previously or thereafter made of the same mental or physical condition.

f. The injured person, upon reasonable request by the insurer or the Unsatisfied Claim and Judgment Fund, shall sign all forms, authorizations**[**,**]**or releases for information, approved by the Commissioner of Insurance, which may be necessary to the discovery of the above facts, in order to reasonably prove the injured person's losses.

g. In the event of any dispute regarding an insurer's or the Unsatisfied Claim and Judgment Fund's or an injured person's right as to the discovery of facts about the injured person's earnings or about his history, condition, treatment, dates and costs of such treatment, or the submission of such injured person to a mental or physical examination subject to the provisions of this section, the insurer, Unsatisfied Claim and Judgment Fund or the injured person may petition a court of competent jurisdiction for an order resolving the dispute and protecting the rights of all parties. The order may be entered on motion for good cause shown giving notice to all persons having an interest therein. Such court may protect against annoyance, embarrassment or oppression and may as justice requires, enter an order compelling or refusing discovery, or specifying conditions of such discovery; the court may further order the payment of costs and expenses of the proceeding, as justice requires.
(cf: P.L.1993, c.186, s.1)

12. This act shall take effect on the 180th day after enactment and shall apply to all requests for reimbursement for medical expenses submitted on or after the effective date.

STATEMENT

This bill is intended to institute cost-savings measures with respect to personal injury protection (PIP) medical expense benefits claims by providing alternatives to the current method of resolving certain disputes involving those claims.

The bill provides that disputes with respect to the amount payable under PIP medical expense benefits and disputes with respect to PIP claims, other than medical expense benefits, would continue to be settled through the current arbitration process. The bill addresses the problem of duplicative billing, with respect to arbitration fees, by requiring that the standards of both the Rules Governing the Courts of the State of New Jersey and the Rules of Professional Conduct for lawyers be applied in determining such fees.

The bill provides that insurers may contract with an approved peer review organization (PRO) in cases in which there is a dispute with respect to the appropriateness or medical necessity of a treatment, medical service or durable medical good.

The bill establishes time frames within which the review process is to be completed, provides for reconsideration of an initial PRO decision by a PRO other than the initial PRO, and provides that the decisions of PROs are subject to review by the Superior Court, Law Division. The bill also establishes the standard for overturning a PRO decision to be "preponderance of evidence."

The bill requires the Commissioner of Insurance to establish, through regulation, standards that an applicant must meet in order to be granted approval as a peer review organization for PIP medical claims expense benefits. Those standards include requirements with respect to experience, licensure, fees, confidentiality and procedures which are necessary to assure the independence and impartiality of the review process.

Institutes cost savings measures with respect to automobile insurance PIP claims.