SENATE, No. 2252

STATE OF NEW JERSEY

INTRODUCED NOVEMBER 17, 1997

By Senators CARDINALE, INVERSO, Kyrillos, Ciesla, Ewing, McNamara, LaRossa and Schluter

AN ACT concerning the review of personal injury protection medical expense benefits by peer review organizations 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 hereby finds and declares that:

a. The enactment of no-fault automobile insurance in New Jersey in 1972 brought with it many benefits for New Jersey drivers, including the payment of benefits for medical expenses for injuries sustained in automobile accidents, without regard to fault; and

b. Although the no-fault system is predicated upon a limitation of the right to sue for noneconomic loss in return for receiving medical expense benefits, medical expense benefits coverage has often been used in contravention of this principle, in order to prove that an injury is serious enough to overcome the limitation on the right to sue; and

c. The improper use of no-fault medical expense benefits has resulted in a significant escalation in the cost of automobile insurance, the average claim for medical expense benefits having increased sevenfold during the past ten years; and

d. In addition to the increased utilization of medical expense benefits, the cost has also been driven higher by general increases in medical costs, which are fueled in part by advancements in medical technology, which has given rise to the overutilization of diagnostic testing; and

e. Under the present system, disputes over the appropriateness of medical treatment for injuries sustained in automobile accidents are subject to a system of arbitration, which results in judgments regarding medical necessity and the appropriateness of medical treatment being made by persons having no medical credentials; and

f. It is necessary to revise the means of judging medical necessity and appropriateness of treatment in order that such decisions may be

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.

made by the professional peers of those performing treatment and to establish a system which is impartial and fair to all parties, and conducted by persons who have no economic interest in the outcome of these decisions.

2. (New section) For the purpose of this act:

a. "Commissioner" means the Commissioner of Banking and Insurance;

b. "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;

c. "Medically necessary" means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury is not primarily for the convenience of the injured person or provider, is the most appropriate standard or level of service which is in accordance with the standards of good practice, as recognized by the provider's professional organizations and licensing board, and does not involve unnecessary or repeated diagnostic testing.

d. "Peer review organization" or "organization" means a group of health care providers 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, which are certified by the commissioner pursuant to section 4 of this act, or any independent health care review company certified 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 to whom the medical expense benefits of personal injury protection coverage apply.

e. "Personal injury protection coverage" is that coverage provided for in sections 4 and 10 of P.L.1972, c.67 (C.39:6A-4 and 39:6A-10).

f. "Health care provider" or "provider" means and shall include, but not be limited to: (1) a hospital or health care facility which is maintained by a state or any of its political subdivisions; (2) a hospital or health care facility licensed by the Department of Health and Senior Services; (3) other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiology and diagnostic testing, freestanding emergency clinics or offices, and private treatment centers; (5) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital; (6) hospitals or other health care facilities or treatment centers located in other states; (7) physicians licensed to practice medicine and surgery; (8) licensed chiropractors; (9) licensed dentists; (10) licensed optometrists; (11) licensed pharmacists; (12) licensed chiropodists;

(13) registered bio-analytical laboratories; (14) licensed psychologists and psychiatric social workers; (15) licensed marriage and family therapists; (16) licensed physical therapists; (17) certified nurse-midwives; (18) licensed health maintenance organizations; and (19) licensed orthotists and prosthetists; (20) providers of other health care services or supplies, including durable medical goods. "Provider" shall not include any practitioner of a religious faith, or any service performed on an emergency basis immediately subsequent to an accident.

3. (New section) The commissioner shall establish standards for the certification of peer review organizations, which shall include standards of performance formulated by the commissioner in consultation with the Commissioner of Health and Senior Services. The standards of performance shall set forth procedures which are reasonable and necessary to ensure an impartial review of the medical necessity or appropriateness of treatments for injuries sustained in an automobile accident, a review of the use of other health care services reimbursable under personal injury protection coverage, and the necessity or appropriateness of the use of durable medical goods. The standards shall ensure the independence and fairness of the review process. The commissioner shall establish standards for the persons who are to conduct reviews, including standards with respect to credentials, experience, licensure, fees and confidentiality. No fee charged by a peer review organization shall be on a contingency basis. The standards shall include a requirement for the number of persons on a panel conducting a review, a requirement that all persons performing reviews are New Jersey licensed or certified health care providers, and a requirement that a panel contain sufficient representation of reviewers as to be able to judge not only the medical necessity and the appropriateness of a treatment, but also to assess the issue of causality.

4. (New section) The commissioner shall certify a peer review organization if the commissioner determines that the applicant has the resources to comply with the standards of performance; has a sufficient number of qualified health care providers, by specialty, to perform the reviews; has a satisfactory procedure for maintaining the confidentiality of medical records; has procedures in effect to guarantee the fair and open exchange of information and records related to reviews between the provider and the organization; is not owned or controlled by an insurer; and has met any other requirements established by the commissioner. "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.

5. (New section) A peer review organization shall be granted certification for a period of five years and shall pay an annual fee to the commissioner as set forth by regulation of the commissioner. The commissioner shall undertake or cause to be undertaken performance audits of an organization's review procedure and its compliance with the standards of performance established by the commissioner. If, at any time, the commissioner determines that the organization no longer meets the standards required for initial certification, if the review procedures of the organization are not being carried out in an impartial and independent manner, or if the organization does not continue to meet the standards of performance established by the commissioner, the commissioner may, after notice and hearing, suspend or revoke the organization's certification. An organization shall submit an annual activity report to the commissioner, in accordance with regulations promulgated by the commissioner, by January 31 of each year.

6. (New section) a. A peer review organization shall utilize in its review of health care providers licensed in New Jersey in the same profession or specialty as the provider whose services are subject to review, or a person familiar with the use or application of a durable medical good, if appropriate. The organization shall establish and utilize written review procedures, which shall be filed with the commissioner. The organization shall conduct its reviews in accordance with the most recent professional protocols which are applicable to the treatment or service to be performed.

b. Every determination made by a peer review organization shall be in writing in accordance with regulations adopted by the commissioner, and shall cite specific findings based upon clinical criteria and consistent with written review procedures on file with the commissioner.

7. (New section) a. Upon the receipt of a bill for treatment or services from a provider, an insurer may refer, through the agent established pursuant to section 8 of this act, a case to a peer review organization for a review of a treatment or course of treatments, health care services provided or to be provided, or a review of the necessity or suitability of durable medical goods which are provided or to be provided to a person injured in an automobile accident for which payment is sought under personal injury protection coverage.

b. The insurer may make a referral to a peer review organization for one or more of the following reasons: (1) if there is substantial evidence that the treatment being given for the injury or the services provided are not medically necessary; (2) if the treatment is not in

accordance with the protocols, professional standards, and the commonly accepted medical practice of providers in the same health care discipline as the treating provider; (3) if the treatment is not consistent with the symptom or diagnosis of the injury; (4) if the treatment appears to be of a palliative, rather than restorative, nature; (5) if the treatment or health care service, including, but not limited to, diagnostic testing, is not related to the injury sustained in the accident, or not required for the diagnosis, evaluation or confirmation of the injury, nor required to assess the effectiveness of the treatment; (6) if the treatment or health care services provided are not in accordance with the provisions of section 4 of P.L.1972, c. 70 (C.39:6A-4), or the terms of the policy; (7) if there appears to have been unnecessary consultations by other health care providers; or (8) if medical procedures, treatment, or testing, which have been repeated, are not medically necessary. No matters regarding the amount or appropriateness of a provider's fee shall be referred to an organization by an insurer.

8. (New section) a. The commissioner shall contract with an independent entity, which is not affiliated with the State, an insurer or a peer review organization, to act as the agent to whom referrals made pursuant to section 7 of this act shall be made. The agent shall maintain a record of (1) all referrals made by each insurer, (2) the reason or reasons cited by the insurer for the referral, (3) all referrals submitted for reconsideration, and (4) the final disposition of the referral. The agent shall forward the referrals to a certified peer review organization on a random basis, so that there is a relatively equal apportionment among all peer review organizations. Referrals shall be made in such a manner so as not to disclose to the peer review organization the identity of the insurer, nor shall the identity of the insurer be disclosed to the organization. Referrals shall be forwarded to the organization by the agent within five business days of receipt. Compensation of the agent shall be funded by assessments on insurers transacting the business of automobile insurance in this State.

b. The agent shall notify the provider and the injured person to whom the treatment, health care service or durable medical goods has been provided, or is to be provided, by certified mail, return receipt requested, within five business days of its referral to the peer review organization: (1) that the referral has been made to a peer review organization, (2) the specific treatment or services which are under review, (3) that payment for the specified treatment or service under review will be withheld by the insurer until a final determination is made by the peer review organization, and (4) that, if the treatment or health care service under review continues during the period before a determination is made by the peer review organization, the treatment or health service may not be reimbursable under the policy. Every

referral by an insurer to the agent shall state specifically the treatment or treatments or health care services being referred for review, and the specific reason that the review is being requested, in accordance with the standards established pursuant to subsection b. of section 7 of this act. Only the treatments or services cited by the insurer in the referral shall be the subject of the review. The injured person shall not be liable for payment for any treatments or health care services performed by a provider which are the subject of the review. The insurer shall remain liable for payment for any treatment or health care service which was performed or is being performed which is not the subject of a review.

c. With the approval of the commissioner, an insurer may require that certain types of durable medical goods be preapproved for payment by the insurer before they are purchased, rented or leased. The requirement for preapproval shall be included in the personal injury protection policy form, and the insured shall be notified separately of this requirement. In the event of a dispute as to the necessity of the purchase, rental or lease of durable medical goods, the insurer may refer the dispute to the agent for referral to a peer review organization for a determination. The organization shall review the proposed use of the durable medical goods, the condition of the injured person and the provider's prognosis for the condition of the injured person and may recommend, if the organization deems the durable medical goods to be medically necessary and appropriate, that the insurer provide payment for the purchase, rental or lease of the durable medical goods, as appropriate. For the purposes of this act, "durable medical goods" shall not include any device used in emergency treatment subsequent to the accident, any device used in connection with the hospitalization of the injured person, or any device used in connection with surgery. An insurer may deny payment, in accordance with the terms of the policy, for any durable medical goods which are purchased, rented or leased by the injured person without a prescription by the provider.

d. Upon notification of a referral of a case which involves admission to a specialized hospital or medical facility, the provider may, within five days of the receipt of the notification, request an expedited review, through the agent, by the peer review organization as to the medical necessity or appropriateness of such admission. The organization shall make its determination within 10 days of the request for the expedited review.

e. If a peer review organization determines that the referral by the insurer is frivolous or that it does not meet the standards for referral established in this act, and that there are no substantial grounds for the referral, the organization shall deny the request for review and return the referral to the agent.

f. If a peer review organization has reason to believe that the

provider, the injured person, or both, may be guilty of fraud, including, but not limited to, that treatment or services for which the insurer was billed were or may not have been actually performed, or that there was misrepresentation as to the nature of the injury, or if it has reason to believe that the provider may be guilty of malpractice, it shall refer the case to the commissioner, who shall refer the case to the Attorney General or the appropriate licensing board, or both, for an investigation.

9. (New section) a. When appropriate in the context of its review of challenged treatments, health care services or durable medical goods, a peer review organization may request and review a provider's projected treatment plan. If, in the course of its review, an organization 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 organization shall report to the insurer through the agent of its recommendations concerning any issue of causality. Such a recommendation shall not be determinative. An insurer may deny payment for the treatment, health care service or durable medical goods on the ground that the treatment, health care service or durable medical goods for which reimbursement is sought is not causally related to the insured event in accordance with the provisions of section 13 of P.L.1972, c.70 (C.39:6A-13).

b. Upon the request of the peer review organization performing a review, a provider whose treatment or services are the subject of the review shall furnish a written report of the history, condition and treatment dates, or the dates services were performed, and shall produce and permit the inspection and copying of the records. The insurer shall reimburse the provider for all reasonable costs in connection with the production of documents. A provider whose treatments, services or prescription for durable medical goods are the subject of a review may request, and shall be granted, expeditiously, an opportunity to discuss his treatments or treatment plans with the organization conducting the review.

c. In any dispute which arises in connection with the review regarding discovery of facts about the injured person's history, condition and treatment dates, or a dispute relative to a mental or physical examination of the injured person, any party to the dispute 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 of any party 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.

10. (New section) a. The peer review organization shall, except in the case of an expedited review pursuant to subsection d. of section 8 of this act, complete its review and make a determination within 30 days of receipt of all requested information from the provider, as provided for in subsection b. of section 9 of this act, except that the time period may be extended no more than 10 days if a request by the provider to discuss his treatment or treatment plan with the organization cannot be honored within the 30-day period.

b. The organization shall submit its determination in writing, in accordance with procedures provided for in subsection b. of section 6 of this act, to the agent, who shall, within three business days, forward a copy to the insurer, the provider and the injured person for whom the reimbursement is claimed by certified mail, return receipt requested. The insurer shall act on the organization's initial determination to make payment or to deny treatment within seven business days of that determination.

11. (New section) An insurer, provider or injured person may request a reconsideration of the peer review organization's initial determination by notifying the agent by certified mail within seven business days of receipt of the determination. The agent shall forward the determination and the accompanying documentation to a peer review organization other than the organization which conducted the initial review. The peer review organization conducting the reconsideration shall afford the requesting party an opportunity to discuss the case with the organization and to file any additional information which was not available at the time of the initial review.

12. (New section) The peer review organization 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 20 days of the receipt of requested information, unless otherwise agreed to by all parties. The organization shall forward its determination to the agent, who shall forward it to the insurer, the provider and the injured person, by certified mail, return receipt requested, within five business days of the receipt of the findings of the organization conducting the reconsideration. The cost of the reconsideration shall be borne by the requesting party if the party is the insurer or the provider, or shall be borne by any other party requesting the reconsideration if other than the injured person.

13. (New section) a. When appropriate, and if provided for in the policy form issued by the insurer, a peer review organization

conducting an initial review or an organization conducting a reconsideration of an initial determination may request an injured person to submit to a mental or physical examination by an independent health care provider, who shall be selected by the organization and who is (1) not affiliated with either the peer review organization requesting the examination or the insurer; (2) licensed in New Jersey in the same profession or specialty as the provider whose services are the subject of the review; and (3) located within a reasonable proximity to the injured person's residence or place of work.

b. The injured person shall provide or make available to the independent provider any pertinent medical records or medical history that the independent provider deems necessary to the examination. The identity of the independent provider shall not be made known to the insurer or the provider whose treatment or services are the subject of the review. The costs of an examination by an independent provider requested by a peer review organization shall be borne by the insurer. The policy form may contain a provision, to be approved by the commissioner, that failure to submit to a mental or physical examination requested by a peer review organization pursuant to this act shall subject the injured person to such limitations in coverage as may be set forth in the policy form. In the case of personal injury protection medical expense benefits payable by the Unsatisfied Claim and Judgment Fund, the commissioner may promulgate rules and regulations governing the failure of an injured person to submit to a mental or physical examination requested by a peer review organization pursuant to this section.

14. (New section) a. If a peer review organization determines that the treatment or service, or a portion thereof, was medically necessary or appropriate, or that certain durable medical goods are necessary or appropriate, given the injuries sustained, the insurer shall pay the provider or injured person, as appropriate, the outstanding amount for that treatment, service or a portion thereof, or for the rental, lease or purchase of the durable medical good, as appropriate.

b. If a peer review organization determines that a health care provider provided unnecessary or inappropriate treatments or services, or that durable medical goods already purchased, rented or leased were not necessary, the provider or injured person, as appropriate, shall not be reimbursed by the insurer for that treatment, service or durable medical good.

c. Within 30 days of the date of notification of an initial determination or a determination made by a peer review organization as the result of a reconsideration, an insurer, provider or injured person may seek review of the dispute by the Superior Court, Law Division. The determination of the peer review organization shall be

presumed to be correct and shall be admissible as evidence at trial upon the request of any party involved in the peer review organization'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 peer review organization's determination was erroneous. Neither the insurer nor the provider, as the case may be, shall be required to pay any amount in dispute until such time as the judicial proceeding is concluded. A provider shall not bill an injured person to which the provisions of this section apply for any medical treatment or health care service which is the subject of a judicial proceeding.

15. (New section) The data maintained by the agent shall be made available to the commissioner, who shall monitor the operation of the peer review system to ensure compliance with the provisions of this act. If the commissioner determines that an insurer has established a pattern of referring cases for review in a manner which is frivolous, making referrals which are not in accordance with the standards set forth in subsection b. of section 7 of this act, which results in a disproportionally high number of claims to be rejected by a peer review organization pursuant to subsection e. of section 8 of this act, or which applies for an excessive number of reconsiderations of initial determinations made by peer review organizations, the commissioner may, after notice and hearing, fine the insurer not less than $5,000 nor more than $10,000, or suspend or revoke the insurer's right to refer cases, or both.

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

5. Payment of personal injury protection coverage benefits.

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 <u>Banking and</u> Insurance and on a form prescribed by the Commissioner of <u>Banking and</u> 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 Banking and 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 Banking and 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 Banking and 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 Banking and 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 Banking and 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 Banking and 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. Written notice to the agent for a referral to a peer review organization pursuant to section 7 of P.L. , c. (C.)(now before the Legislature as this bill) shall satisfy the notice request for additional time to investigate a claim pursuant to this subsection. 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.

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.

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.

i. All automobile insurers and the Unsatisfied Claim and Judgment Fund shall provide any claimant with the option of submitting a dispute **[**under this section**]** to binding arbitration if the dispute arose pursuant to the following provisions: subsections b., c., d. and e. of section 4

of P.L.1972, c.70 (C.39:6A-4); subsection b., c., d. and e. of section 7 of P.L.1972, c.198 (C.39:6-86.1); additional first party coverage benefits required to be offered pursuant to section 10 of P.L.1972, c.70 (C.39:6A-10) or 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**]** approved by the commissioner which are in conformance with New Jersey law and consistent with the Legislature's intent as stated in section 1 of P.L. , c. (C.)(now before 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 New Jersey 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 causally related to an insured event, shall not be subject to binding arbitration.
(cf: P.L.1995, c.407, s.1)

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

13. Discovery of facts as to personal injury protection coverage. 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 Banking and 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 examination 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 regulations promulgated by the commissioner.

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 Banking and 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)

18. This act shall take effect on the 180th day following enactment

STATEMENT

This bill institutes cost-saving measures with respect to personal injury protection (PIP) medical expense benefits claims by providing another way of resolving certain disputes involving those claims. The bill provides for independent, unbiased peer review organizations

(PROs) to determine the necessity and appropriateness of treatment, services or durable medical goods provided to persons covered by PIP insurance when there is a dispute between an insurer and either a health care provider or a claimant.

The commissioner shall certify an applicant to be a PRO if the applicant: has a sufficient number of health care providers, by specialty, to perform the medical reviews; uses only health care providers licensed in New Jersey; provides for confidentiality of individual medical records; guarantees the fair and open exchange of information and records concerning reviews between the health care providers and the PRO; is not owned or controlled by an insurer; and meets any other requirements that the commissioner deems relevant. A certified PRO may perform reviews for five years but that authority may be suspended or revoked if the commissioner determines that the review procedures are not being carried out in compliance with the provisions of the bill.

A PRO shall conduct its reviews in accordance with the latest medical protocols generally accepted within the health care professions. Compensation for the services of a PRO shall not be on a contingency fee basis.

Upon receipt of a bill for treatment or services from a provider, an insurer may refer the case to a PRO for review of the treatment, health care services provided or the necessity or suitability of durable medical goods. The referral may be made for one or more of the following reasons: (1) if there is substantial evidence that the treatment being given for the injury or the services provided are not medically necessary; (2) if the treatment is not in accordance with the protocols, professional standards, and the commonly accepted medical practice of providers in the same health care discipline as the treating provider; (3) if the treatment is not consistent with the symptom or diagnosis of the injury; (4) if the treatment appears to be of a palliative, rather than restorative, nature; (5) if the treatment or health care service, including, but not limited to, diagnostic testing, is not related to the injury sustained in the accident, or not required for the diagnosis, evaluation or confirmation of the injury, nor required to assess the effectiveness of the treatment; (6) if the treatment or health care services provided are not in accordance with the provisions of section 4 of P.L.1972, c.70 (C.39:6A-4), or the terms of the policy, (7) if there appear to have been unnecessary consultations by other health care providers, or (8) if medical procedures, treatment or testing, which have been repeated, are not medically necessary.

The commissioner shall appoint an agent to whom referrals shall be made and the agent will distribute them to certified PROs. The agent shall make referrals at random to certified PROs. An insurer is not required to pay the provider for services subject to a PRO review until there is an initial determination by the PRO.

An insurer, provider or injured person may request a reconsideration of a PRO's initial determination by another PRO. A reconsideration shall be completed within 20 days of receipt of all requested information. If the party is the insurer or the provider, the requesting party shall bear the costs of any reconsideration of a PRO determination.

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 the review; and located within a reasonable proximity to the injured person's residence. The insurer shall bear the cost of that examination.

When a PRO determines that the treatment or service was medically necessary or appropriate, the insurer must pay the provider or claimant the outstanding amount.

If a PRO determines that a health care provider provided unnecessary or inappropriate medical treatments, health care services or durable medical goods, the provider may not be reimbursed by the insurer for those costs.

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 Superior Court review of the dispute. A PRO determination is presumed correct when reviewed by a court. The PRO's determination may only be overturned by a preponderance of evidence showing that the PRO determination was erroneous.

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 arbitration proceedings are to be administered and subject to procedures approved by the commissioner. Currently, the arbitration proceedings are administered and subject to procedures established by the American Arbitration Association. The bill also 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 New Jersey Rules of Professional Conduct for attorneys be applied in determining such fees.

Provides for the review of PIP medical expense benefits by peer review organizations.