SENATE, No. 2291

STATE OF NEW JERSEY

INTRODUCED DECEMBER 1, 1997

By Senator MacINNES

AN ACT concerning the review of medical expense benefits claims under automobile insurance personal injury protection coverage 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) As used in this act:

"Commissioner" means the Commissioner of Banking and 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;

"Personal injury protection coverage" is that coverage provided for in sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10);

"Provider of health care services" or "provider" means and includes, but shall 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, as designated by the Department of Health and Senior Services to provide health care services; (4) a registered nursing home providing convalescent care; (5) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital; (6) hospitals or

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 thus is new matter.

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 and Senior Services; (7) nonprofit hospital, medical or health service plans of other states approved by the commissioner; (8) physicians licensed to practice medicine and surgery; (9) licensed chiropractors; (10) licensed dentists; (11) licensed optometrists; (12) licensed pharmacists; (13) licensed chiropodists; (14) registered bio-analytical laboratories; (15) licensed psychologists; (16) licensed physical therapists; (17) certified nurse-midwives; (18) registered professional nurses; (19) licensed health maintenance organizations; and (20) providers of other similar health care services or supplies as approved by the commissioner.

2. (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 and Senior Services, 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, shall include standards with respect to experience, licensure, fees and confidentiality, and shall provide for a rotating group of health care providers with more than half of their income produced from the actual practice of their profession, excluding income from medical reviews.

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 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 any other requirements which the commissioner deems 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 subsections 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, the commissioner may order the insurer to reduce the number of cases being referred for review by PROs, except that an insurer shall not refer annually more than 5% of its cases for review.

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.

3. (New section) a. An insurer may file a request with the commissioner for an independent review of treatments, health care services, or durable medical goods provided to any person injured as a result of an automobile accident, who is receiving personal injury protection coverage benefits, by an approved peer review organization. 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 commissioner of its recommendation concerning any issue of causality and the commissioner shall notify the insurer thereof. Such a recommendation by a PRO shall not be determinative. An insurer may deny 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.

No emergency care provided in a hospital immediately subsequent to an accident shall be subject to review.

b. An insurer that seeks to have an independent review as provided in this section shall file a request with the commissioner within 20 days of the insurer's receipt of a bill for treatment, health care services, or durable medical goods. The commissioner shall refer the request for the independent review to an approved PRO within 20 days of the receipt of the request.

c. The commissioner and the Commissioner of Health and Senior Services shall jointly establish and administer a process for referring requests for independent reviews by approved PROs. The process shall:

(1) provide that referrals be made on a random and rotating basis to ensure that no single PRO or group of PROs is being utilized by an insurer all or substantially all of the time;

(2) ensure that the identities of the PRO and the providers performing the independent review are not revealed to the insurer; and

(3) be otherwise consistent with the provisions and purposes of this act.

d. The commissioner shall establish a schedule of fees to cover the costs of using the referral process created in this section. The cost of the referral process and the independent review shall be borne by the party requesting the independent review.

4. (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.

5. (New section) a. An insurer's request for an independent review shall be filed with the commissioner within 20 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 there is an initial determination by the PRO, except as otherwise provided in subsection d. or g. of this section. An insurer shall notify a provider or injured person, as appropriate, in writing, by certified mail, when a request for an independent review has been filed with the commissioner that the insurer is not required to pay the provider or injured person, as appropriate, who is the subject of the request 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. The PRO shall forward a copy of its written determination to the commissioner, who shall forward the written determination to the insurer that requested the independent review. 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; and 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 using the referral process established in section 3 of this act 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. The 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 notify the provider and 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 provider, 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 provider any pertinent medical records or medical history that the independent provider deems necessary to the examination. The costs of an examination requested by a PRO shall be borne by the insurer. Insurers providing personal injury protection medical expense benefits coverage may 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, health care service or durable medical good was medically necessary or appropriate, the insurer shall pay the provider or claimant, as appropriate, the outstanding amount. 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 as provided in subsection g. of section 5 of P.L.1972, c.70 (C.39:6A-5).

(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 not medically necessary or appropriate, the provider or injured person shall return the amount paid, plus interest at the rate established for post-judgment interest 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 or injured person. 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 by the commissioner of an initial or final determination by a PRO, an insurer, provider or injured person may seek review of the determination by the Superior Court, Law Division. The determination of the PRO shall be admissible as evidence at trial upon the request of any party involved in the PRO's review. A trial to affirm or overrule a determination by a PRO shall be conducted before a judge and shall take place within 90 days of the request for review to the Superior Court, Law Division. The insurer shall not be required to pay any amount in dispute until the judicial proceeding is concluded. A provider shall not bill an injured person to whom 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.

6. 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 Banking and Insurance and on a form prescribed by the Commissioner of Banking and 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. A written request for a referral to a peer review organization pursuant to section 3 of P.L. , c. (C.)(now before the Legislature as this bill) shall constitute a written notice of the need 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. Notwithstanding the provisions of this subsection, an insurer may refer a claim or bill, as appropriate, to

the commissioner for review by a peer review organization pursuant to section 3 of P.L. , c. (C.)(now before the Legislature as this bill), no later than 20 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 section 5 of P.L. , c. (C.) (now before the Legislature as this bill).

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. 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 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)

7. 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 subsection. 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 subsection 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)

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

STATEMENT

This bill allows insurers to refer personal injury protection (PIP) medical expense benefits claims to an approved peer review organization (PRO). The PRO would review the appropriateness or medical necessity of a treatment, medical service or durable medical equipment.

The bill creates a "screen" between the PRO and the insurer in order to keep the peer review process unbiased and anonymous. In order to refer a claim to peer review, the insurer must file a request for a review with the Department of Banking and Insurance, which will then forward the request to an approved PRO. The process will ensure that referrals are made on a random and rotating basis, so that no single PRO or group of PROs is being utilized by an insurer all or substantially all of the time, and that the identity of the PRO and the identities of the providers performing the independent review are not revealed to the insurer. The commissioner shall establish a schedule of fees for insurers to cover the costs of peer reviews and for the use of the referral process.

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 requires the Commissioner of Banking and Insurance to establish standards for approval as a PRO for PIP medical expense benefits claims. Those standards will include requirements with respect to experience, licensure, fees, confidentiality and procedures, which are necessary to ensure the independence and impartiality of the review process, including standards to provide for a rotating group of health care providers with more than half of their income produced from the actual practice of their profession, excluding income from medical reviews.

Consumer safeguards include: prohibition on PRO review of emergency care provided in a hospital immediately subsequent to an automobile accident; prohibition on PRO compensation based upon a

percentage or contingency basis; prohibition on insurer ownership of a PRO; the commissioner's ability to suspend or revoke a PRO's authority if the commissioner determines reviews are not being carried out in an impartial and independent manner; and the commissioner's ability to order a reduction in the number of PRO reviews referred by an insurer, if the commissioner determines that too many referrals are being made, except that the bill provides that an insurer cannot refer more than 5% of its cases annually.

Disputes concerning the amount payable under PIP medical expense benefits, and disputes concerning PIP claims, other than medical expense benefits, would continue to be settled through an arbitration process, but the bill requires that the arbitration procedures be approved by the Commissioner of Banking and Insurance.

Provides for review of automobile insurance personal injury protection medical expense benefits by peer review organizations.