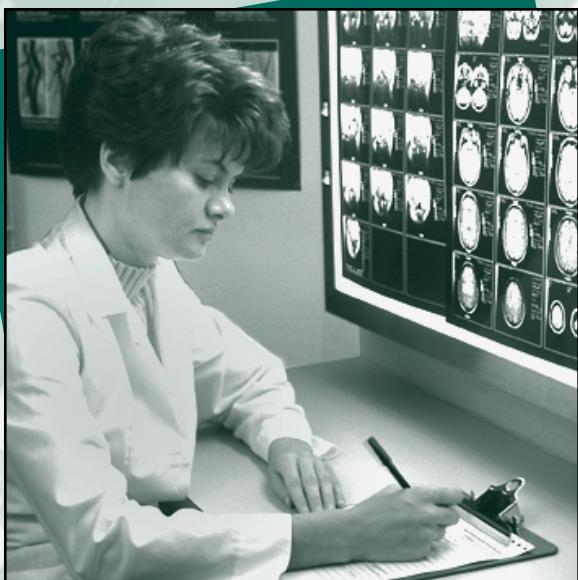


*Helping Medical Professionals*  
Understand AICRA



Insurance Council of New Jersey



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*For almost thirty years, New Jersey has wrestled with attempts to create a better automobile insurance system.*

*In May 1998, after many months of investigation and debate, the Automobile Insurance Cost Reduction Act of 1998 (AICRA) received bipartisan approval by the state Legislature and was signed into law by Governor Christine Todd Whitman.*

*The AICRA reform brought about a number of dramatic changes to the state's auto insurance system that impact medical professionals and the treatment of automobile accident victims. This booklet is designed to assist medical professionals in understanding AICRA's intent and the elements of the new statute and regulations.*

Insurance Council of New Jersey



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# Background

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The concept of no-fault or personal injury protection (PIP) coverage is simple. Medical bills, lost wages and other costs associated with auto-accident injuries are paid no matter who is at fault in an accident. No-fault is much different from pure liability systems in other states. Those systems require the more seriously injured accident victim to prove that the other party was at fault in order to receive compensation from an auto insurance policy, a process that often takes a long time.

The intent of the new law is to “more precisely define the benefits available under the medical expense benefits coverage (PIP), and establish standard treatment and diagnostic procedures against which the medical necessity of treatments reimbursable under medical expense coverage would be judged” (New Jersey Statute C.39: 6A-1.1).

In anticipation of the savings this would generate, the Legislature required automobile insurers to reduce premiums by fifteen percent (15%) or approximately \$750 million.

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# Coverage Limits

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Under AICRA, consumers have new choices with regard to their personal injury protection or PIP benefits coverage, which pays medical expenses resulting from

injuries to drivers and their passengers no matter who is at fault in an accident. Consumers now have several choices with regard to PIP benefits, depending on whether they purchase a “standard” auto insurance policy or a new “basic” policy.

## ***Basic Policy***

The new basic policy allows vehicle owners to purchase a lesser amount of personal injury protection coverage than the law previously required. The new basic policy offers only \$15,000 in personal injury protection coverage, but also includes up to \$250,000 of medical benefits coverage for catastrophic-type injuries (see Definitions).

Basic policies also offer \$5,000 of property damage liability coverage and an option to purchase \$10,000 of bodily injury liability coverage. Policyholders who purchase a basic policy cannot purchase uninsured/underinsured motorist coverage. Companies can, at their option, also offer to sell collision and comprehensive coverage with this type of policy.

## ***Standard Policy***

Under AICRA, individuals purchasing a standard policy have the option of choosing PIP benefits coverage levels of \$250,000, \$150,000, \$75,000, \$50,000 or \$15,000. All the options include catastrophic-type injury coverage of up to \$250,000. If a policyholder does not choose among these options, he/she will automati-

cally be given the standard \$250,000 of coverage.

Under a standard policy, the minimum amount of bodily injury liability coverage required is \$15,000 for injuries to one person and \$30,000 for all injuries in an accident. The minimum amount of property damage liability coverage required is \$5,000. Additionally, standard policies offer uninsured/underinsured motorist coverage with the same minimum limits as for liability coverages and a basic deductible of \$500 for property damage. Collision and comprehensive coverages are also available in the standard policy.

All PIP patients are responsible for the standard \$250 deductible and 20 percent co-payment on medical expense benefits between \$250 and \$5,000, regardless of whether they purchase the basic or standard policy. Insurers are also required to offer policyholders the option of selecting higher PIP deductibles of \$500, \$1,000, \$2,000 or \$2,500. As a result of recent reforms, most policies also have a variety of co-pay deductibles.

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## Initial Notification

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**W**hen a medical provider first begins treating a patient with auto-accident related injuries, the following information should be obtained from the injured person

and provided to the automobile insurance company to determine if PIP coverage is available:

- **Injured person's name**
- **Name of policyholder, if different from injured person**
- **Name of automobile insurance company**
- **Policy number**
- **Claim number, if available**
- **Date of accident**
- **Injured person's Social Security number**
- **Injured person's date of birth**
- **Telephone number of injured person**

Health care providers treating those injured in automobile accidents are responsible under state regulation for making prompt notification of the commencement of medical treatment to the patient's automobile insurance company. Notification allows the insurer to provide company-specific information on decision-point review requirements and any pre-certification programs that may exist. These programs vary slightly from company to company.

### ***Insurance ID Card***

Insurance company contact information can be found on the reverse side of the policyholder's automobile insurance identification card. Requesting the actual insurance identification card from the policyholder will provide you the opportunity to obtain critical policy information required by the

insurance company to verify coverage. A complete listing of all automobile insurance company contact information for PIP treatment notification can be found at [www.naic.org/nj/21daycon.htm](http://www.naic.org/nj/21daycon.htm) or [www.njpip.com](http://www.njpip.com).

The treating physician should also try and determine if the injured party has completed, signed and filed an *Application for Benefits – Personal Injury Protection* form with their automobile insurance company. The automobile insurance company cannot make any payment for services until this form is completed, signed and filed.

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## Care Paths

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AICRA required the New Jersey Department of Banking & Insurance to establish guidelines for the standard treatment of certain injuries sustained in automobile accidents.

After months of research and dialogue with the state's various medical licensing boards, the Department approved a set of medical treatment guidelines or Care Paths and a list of valid diagnostic tests as the standard course of treatment for soft tissue injuries of the neck and back resulting from automobile accidents. A copy of the Care Paths is available on the Department's web site at [www.njdoibi.org](http://www.njdoibi.org).

Care Paths provide that treatment be evaluated at certain intervals called decision points. Treatments that vary

from the prescribed Care Paths will be reimbursable only when warranted by reason of medical necessity.

*It is important to note, however, that the medical treatment guidelines do not apply to treatment administered during emergency care or within the first 10 days after the accident causing the injury.*

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## Decision-Point Review

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The Department of Banking & Insurance has published standard courses of treatments called Care Paths for the diagnostic testing and treatment of soft tissue injuries of the neck and back resulting from automobile accidents. These Care Paths provide that treatment be evaluated at certain intervals called decision points. The decision to administer one of the tests listed on page 6 of this booklet are also decision points for all injuries. The Department has established parameters for these tests which are available on their web site at [www.njdoibi.org](http://www.njdoibi.org).

At such decision points the treating medical professional must communicate information about further treatment and/or testing they intend to prescribe for the injured individual to the automobile insurance company or its designated representative. This allows both the treating medical provider and the automobile insurance company an opportunity to periodically review the course of

treatment and discuss if it is the most appropriate level of care. If the treating medical provider fails to submit requests for decision-point reviews, payment of bills may be subject to additional co-payments, even if services are determined to be medically necessary, as approved by the Department of Banking and Insurance.

An insurer has three business days to respond to your decision-point review. As a medical provider, if you do not hear from the patient's insurance company regarding your request within three business days, you may continue treatment.

In certain circumstances, the insurer may require the injured party to undertake an independent physical examination. The insurer is required to schedule this medical exam within seven calendar days and it must be conducted by a health care provider in the same discipline as the treating provider, and must be conducted at a location reasonably convenient to the patient. Treatment may proceed while the exam is being scheduled and until the results are available.

Any decision not to certify treatment or tests by an insurer must be made by a physician. If a decision is made not to provide further benefits, the patient may either discontinue treatment, appeal the decision to the company's internal appeal process or contest the decision through the dispute resolution process (see PIP Dispute Resolution System).

*Decision-point requirements do not apply during emergency care performed in a hospital emergency room or within the first 10 days of the insured accident.*

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## Pre-certification

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AICRA provides that insurers may require pre-certification of certain treatments, procedures, diagnostic tests, other services and durable medical equipment that are not subject to decision-point review and that may be subject to overutilization.

The following list provides examples of the types of treatment and testing which may be required to be pre-certified by individual automobile insurance companies:

- **non-emergency hospital stays;**
- **non-emergency surgical procedures;**
- **specified services provided by physical therapists;**
- **specified services provided by chiropractors;**
- **durable medical equipment;**
- **home health care;**
- **hospice care;**
- **infusion therapy;**
- **prosthetic devices; and**
- **prescription drugs.**

*Pre-certification does not apply to treatment or diagnostic tests administered during emergency care performed in a hospital emergency room or during the first 10 days after the accident causing the injury.*

*All treatment within the first 10 days after the accident causing the injury, however, must be medically necessary to be reimbursable.*

Pre-certification **does not** require prior authorization for each and every treatment in the course of providing medically necessary care.

Each company has detailed information on how to make pre-certification requests that will be supplied to you when the patient's insurer receives notice of the claim. The patient's insurer must respond to your request for precertification within 3 business days. If you do not hear from the insurer within 3 business days, you may proceed with the planned treatment.

Every insurer's pre-certification plan includes an internal appeal system that allows the provider to have a denial or modification of their request reviewed. Providers also have the opportunity under the appeal system to provide additional information, if the request for certification is denied or modified.

However, if the pre-certification requirements in the policy covering the injured person's benefits are not met, expenses for medically necessary treatment and testing are subject to additional co-payment penalties of up to 50 percent.

Pre-certification **does not** mandate the use of certain health care providers or facilities. Some pre-certification plans do include provisions that

durable medical equipment, diagnostic tests and prescription drugs be obtained directly from a licensed and certified supplier designated by the insurer to avoid co-pay deductibles (See "Voluntary Networks" on page 8).

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## Diagnostic Testing

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**U**nder AICRA, certain diagnostic tests are no longer reimbursable under PIP as they have been determined by state regulators and the various licensing boards to yield no data of any significant value in the development, evaluation and implementation of an appropriate plan of treatment for injuries sustained in automobile accidents. Insurers are no longer permitted to pay for:

- spinal diagnostic ultrasound,
- iridology,
- reflexology,
- surrogate arm mentoring,
- surface electromyography (surface EMG), and
- mandibular tracking and stimulation.

Personal injury protection medical expense coverage also does not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment

plan employed to treat TMJ/D:

- Mandibular tracking,
- Surface EMG,
- Sonography,
- Doppler ultrasound,
- Needle EMG,
- Electroencephalogram (EEG),
- Thermograms/thermographs,
- Video fluoroscopy, and
- Reflexology.

PIP medical expense benefit coverage will provide for reimbursement of certain diagnostic tests, which have been determined to have value in the evaluation of injuries, the diagnosis and the development of a treatment plan for personal injuries in a covered accident, when medically necessary and consistent with clinically supported findings. A list of the diagnostic tests and their parameters can be found on page 12 of this brochure under "Limits on Diagnostic Testing."

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## Assignment of Benefits

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As the medical provider for a patient with injuries resulting from an automobile accident, your patient may wish to assign his/her medical expense benefits to you. Be aware that many insurance companies put certain conditions on the assignment of benefits. Contact the patient's insurer to determine their

policy regarding the assignment of benefits and any restrictions they may have.

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## PIP Dispute Resolution System

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Prior to the reform law, disputes over excessive medical treatment were resolved by panels of lawyers – not doctors – and a typical claim could take 12 to 18 months to be processed. Under the new arbitration system, new procedures have been established and implemented for the resolution of disputes concerning the payment of medical expenses and other benefits provided under a patient's PIP coverage.

Under the new dispute resolution system, full-time professional arbitrators review and render decisions concerning disputes regarding PIP medical benefits. All decisions rendered are in writing and are binding.

Disputes regarding medical expense benefits may include, but are not limited to,

- **matters concerning interpretation of the PIP provisions;**
- **whether the treatment is in accordance with the provisions of applicable statutes and rules or the terms of the policy;**
- **the eligibility of treatment for**

- **compensation or reimbursement;**
- **the eligibility of the provider to be compensated or reimbursed under the terms of the policy or the provisions;**
- **whether the treatment was actually performed;**
- **whether the diagnostic tests performed are recognized ones;**
- **the necessity and appropriateness of consultation with other health care providers;**
- **disputes regarding the auto insurance medical fee schedule, and**
- **whether the treatment is reasonable, necessary and in accordance with the medical protocols.**

If there is a dispute regarding Personal Injury Protection coverage, any party involved may request a resolution of the dispute. The request for dispute resolution must be made in writing to the designated dispute resolution organization and copies sent to the other parties. Once the dispute resolution organization receives the request, the matter will be assigned to a dispute resolution professional.

### ***Medical Review Organizations***

Either party involved in an arbitration proceeding concerning PIP benefits can seek to have the matter reviewed by a medical review organization (MRO). These independent medical review organizations are reviewed and certified by the Department of

Banking & Insurance and must be capable of performing reviews for all primary specialties and disciplines.

In addition, the MRO must utilize health care professionals in the same disciplines as the treating providers, be licensed in New Jersey, actively practicing, and be board certified in their specialty.

### ***Utilizing the PIP Dispute Resolution System***

Any party filing the appropriate information and paying the required administrative fee may initiate arbitration. The American Arbitration Association administers the PIP Dispute Resolution System. They can be reached at (732) 560-9560. *The Rules for the Arbitration of No-Fault Disputes in the State of New Jersey* can be found on the A.A.A.'s web site at [www.adr.org](http://www.adr.org).

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## **Voluntary Networks**

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Most automobile insurance companies will encourage policyholders to utilize a voluntary network vendor for certain durable medical equipment, diagnostic testing and prescription drugs. If your patient selects a vendor from the voluntary network, their co-payment for that service will be reduced in full or in part. Use of these networks is strictly voluntary.

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## Deductibles and Co-payments

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AICRA encouraged automobile insurance companies to offer various deductible and co-payment plans within their PIP medical benefits coverage. PIP patients are still responsible for the standard \$250 deductible and 20 percent co-payment on medical expense benefits between \$250 and \$5,000 regardless of whether they purchase the basic or standard policy. Insurers are also required to offer policyholders, at appropriately reduced premiums, the option of selecting a PIP deductible of \$500, \$1,000, \$2,000 or \$2,500.

Automobile insurers can require that the insured advise and inform them about their injury and claim in a timely manner. If such a request for information is disregarded, an additional co-payment of 25 percent will apply if the requested information is received 30 or more days after the accident or 50 percent when received 60 or more days after the accident. Any reduction in the amount of reimbursement for PIP claims will be in addition to any other deductible or co-payment requirement.

Individual automobile insurance companies may also require co-payments for certain goods or services received during the course of treating accident-related injuries.

All deductibles and co-payments apply on a per accident basis.

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## New Definitions

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The reform law required insurers to include new definitions in their automobile insurance policies. These definitions are meant to more precisely define benefits available under PIP and combat unnecessary treatment.

**“Care Paths”** refers to a recommended extensive course of care for a particular injury based on professionally recognized standards.

**“Catastrophic injury”** — in a case where the policyholder has elected PIP coverage in an amount less than the standard \$250,000, medical expense benefits shall be paid in an amount not to exceed \$250,000 for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care, and can be safely discharged or transferred to another facility in the judgment of the attending physician.

**“Clinically supported”** means that a health care provider prior to selecting, performing, or ordering the administration of a treatment or diagnostic test has: 1) personally examined the patient to ensure that the proper medical indications

exist to justify ordering the treatment or test; 2) physically examined the patient, including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications and physical tests; 3) considered any and all previously performed tests that relate to the injury and the results which are relevant to the proposed treatment or test, and 4) recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

**“Decision point”** means those junctures in the treatment of identified injuries where a decision must be made about the continuation or choice of further treatment.

**“Diagnostic test”** means a medical service or procedure utilizing bio-mechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical, dental, physical therapy, chiropractic or psychological diagnosis, for the purpose of recommending or developing a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

**“Eligible charge”** means the treating health care provider's usual, customary and reasonable charge or the upper limit of the medical fee schedule, whichever is lower.

**“Emergency care”** means all medically necessary treatment of a

traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death, serious impairment to bodily function, or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, and critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident.

**“Health care provider” or “provider”** means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to, (1) a hospital or health care facility that is maintained by 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 radiological and diagnostic testing, free-standing emergency clinics or

offices, and private treatment centers, (4) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital, (5) hospitals or other health care facilities or treatment centers located in other states or nations, (6) physicians licensed to practice medicine and surgery, (7) licensed chiropractors, (8) licensed dentists, (9) licensed optometrists, (10) licensed pharmacists, (11) licensed chiropractists, (12) registered bio-analytical laboratories, (13) licensed psychologists, (14) licensed physical therapists, (16) certified nurse mid-wives, (17) certified nurse-practitioners/clinical nurse-specialists, (18) licensed health maintenance organizations, (19) licensed orthotists and prosthetists, (20) licensed professional nurses, and (21) providers of other health care services or supplies, including durable medical goods.

**“Hospital expenses”** means the cost of treatment and services, as provided in the policy approved by the Commissioner, by a licensed and accredited acute care facility which engages primarily in providing diagnosis, treatment and care of sick and injured persons on an inpatient or outpatient basis; the cost of covered treatment and services provided by an extended care facility which provides room and board and skilled nursing care 24 hours a day and which is recognized by the administrators of the federal Medicare program as an extended care facility, and the cost of covered services at an

ambulatory surgical facility supervised by a physician licensed in this state or in another jurisdiction and recognized by the Commissioner of Health and Senior Services, or any other facility licensed, certified or recognized by the Commissioner of Health and Senior Services or the Commissioner of Human Services or a nationally recognized system such as the Commission on Accreditation of Rehabilitation Facilities, or by another jurisdiction in which it is located.

**“Identified injuries”** means those injuries identified by the Department of Banking and Insurance as being suitable for medical treatment protocols.

**“Medical expenses”** means reasonable and necessary expenses for treatment or services as provided by the policy, including medical, surgical, rehabilitative and diagnostic services and hospital expenses, provided by a health care provider licensed or certified by the state or by another state or nation, and reasonable and necessary expenses for ambulance services or other transportation, medication and other services as may be provided for, and subject to such limitations as provided for, in the policy, as approved by the Commissioner.

“Medical expenses” shall also include any nonmedical remedial treatment rendered in accordance with a recognized religious method of healing.

**“Medically necessary”** means that the treatment is consistent with

the symptoms or diagnosis, and treatment of the injury (1) is not primarily for the convenience of the injured person or provider, (2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols, as such protocols may be recognized or designated by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services or with a professional licensing or certifying board in the Division of Consumer Affairs in the Department of Law and Public Safety, or by a nationally recognized professional organization, and (3) does not involve unnecessary diagnostic testing.

**“Pre-certification”** means a program by which the medical necessity of certain diagnostic tests, medical treatments and procedures are subject to prior authorization, utilization review and/or case management.

**“Significant disfigurement”** means the result and/or manifestation of a serious traumatic injury that is observable as a permanent and substantial defect in the appearance and functional ability of the person injured. “Significant disfigurement” is a serious outward change that substantially detracts from the appearance and functional ability of the person injured.

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## Limits on Diagnostic Testing

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

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

**Electroencephalogram (EEG)** – when used to evaluate head injuries, where there are clinically supported findings of an altered level of sensorium and/or a suspicion of seizure disorder. This test, if indicated by clinically supported findings, can be administered immediately following the insured event. When medically

necessary, repeat testing is not normally conducted more than four times per year.

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

**Magnetic resonance imaging (MRI)** – when used in accordance with guidelines contained in the American College of Radiology, Appropriateness Criteria to evaluate injuries in numerous parts of the body, particularly the assessment of nerve root compression and/or motor loss. MRI is not normally performed within five days of the insured event. However, clinically supported indication of neurological gross motor deficits, incontinence or acute nerve root compression with neurologic symptoms may justify MRI testing during the acute phase immediately post injury. In the case of TMJ/D where there are clinical signs of internal derangement such as nonself-induced clicking, deviation, limited opening, and pain with a history of trauma to the lower jaw, an MRI is allowable to show displacement of the condylar disc, such procedure following a panoramic or transcranial x-ray and six or eight weeks of conservative treat-

ment. This TMJ/D diagnostic test may be repeated post surgery and/or post appliance therapy.

**Computer assisted tomographic studies (CT, CAT Scan)** – when used to evaluate injuries in numerous aspects of the body. With the exception of suspected brain injuries, CAT Scan is not normally administered immediately post injury, but may become appropriate within five days of the insured event. Repeat CAT Scans should not be undertaken unless there is clinically supported indication of an adverse change in the patient's condition. In the case of TMJ/D where there are clinical signs of degenerative joint disease as a result of traumatic injury of the temporomandibular joint, tomograms may not be performed sooner than 12 months following traumatic injury.

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

**Sonograms/ultrasound** – when used in the acute phase to evaluate the abdomen and pelvis for intra-abdominal bleeding. These tests are not normally used to assess joints (knee and elbow) because other tests are more appropriate. Where MRI is performed, sonogram/ultrasound is not necessary. However,

echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

**Thermography/thermograms** - only when used to evaluate pain associated with reflex sympathetic dystrophy (“RSD”), in a controlled setting by a physician experienced in such use and properly trained.

**Brain mapping** - when done in conjunction with appropriate neurodiagnostic testing.

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

Except in cases of emergency care, a determination to administer any of the above tests shall be subject to decision-point review.

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## PIPTAC

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The Commissioner of the Department of Banking & Insurance (DOBI) has established the Personal Injury Protection Technical Advisory Committee (PIPTAC) to assist the DOBI in ensuring that reimbursement for medically necessary care of injuries sustained in automobile accidents is being appropriately and properly implemented, to review the standards for the treatment of common automobile accident-related injuries, and to periodically report to the Legislature.

### Complaints

PIPTAC is asking any medical provider who is experiencing problems related to the new AICRA reforms to contact PIPTAC through Tom Smith of the Division of Enforcement & Consumer Complaints. A Consumer Complaint Form can be obtained via the Internet at [www.naic.org/nj/consumer.htm](http://www.naic.org/nj/consumer.htm). The information must be forwarded to the attention of Tom Smith by fax to (609) 292-5865 or mailed to:

Tom Smith  
PIPTAC  
Division of Enforcement  
& Consumer Complaints  
P.O. Box 329  
Trenton, NJ 08625-0329

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