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OVERVIEW OF NJ PIP LAW

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The New Jersey Personal Injury Protection (PIP)/"No Fault" statute, N.J.S.A. 39:6A-1, *et seq.*, mandates speedy first-party payment of a range of benefits, including medical expenses, lost wages (income continuation benefits), essential services, survivor benefits and funeral expenses to certain classes of persons injured in automobile accidents without any consideration of fault at all. Prior to the passage of the AICRA Act in 1998, standard PIP coverage provided a mandatory minimum limit of \$250,000 in medical expense benefit coverage. The AICRA Act reduced and limited mandatory minimum PIP coverages previously required in New Jersey by making those coverages dependant on the choices made by consumers regarding their own economic status.

"Standard" coverage now makes the previously mandatory \$250,000 medical expense benefit the default option, while providing for optional reduced coverage limits at \$15,000, \$50,000, \$75,000 and \$150,000. If the policyholder chooses "basic" PIP coverage, the medical expense benefit coverage is only \$15,000 per person per accident, but allows for additional coverage not to exceed \$250,000 for limited catastrophic specific injuries including permanent brain damage, spinal cord injury, disfigurement, or "other permanent and significant injuries" treated at an acute care hospital immediately after an accident. Other PIP benefits available under a "standard" policy, such as income continuation, essential services, or death benefits, are not included in "basic" policy coverage. A third class of insurance, denominated a "special" policy, is eligible to only low income individuals. It provides for even more limited coverage than the "basic" policy, but does allow for a \$10,000 death benefit.

Eligible "medical expenses":

Pursuant to AICRA, coverage will only be allowed for those treatments, tests and services provided for in the policy of insurance. "Medical expenses" is defined in the Act as meaning "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 also including any non-medical or remedial treatment rendered in accordance with a recognized religious method of healing." N.J.S.A. 39:6A-2(e). The Act defines "hospital expenses" at N.J.S.A. 39:6A-2(f), and defines eligible "health care providers" at N.J.S.A. 39:6A-21.

To be payable by PIP, medical expenses must be reasonable and "medically necessary" which is defined by the Act as meaning "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...., and (3) does not involve unnecessary diagnostic testing." N.J.S.A. 39:6A-2(n).

Income continuation benefits:

A claimant eligible for “standard” PIP coverage may recover income continuation benefits, i.e., the payment of the loss of income of an “income producer” as a result of bodily injury disability. The default coverage is subject to a maximum weekly payment of \$100, subject to a maximum limit of \$5,200 on account of injury to any one person in any one accident. Income continuation benefits are payable upon written notice of loss, but cannot exceed the net income of the injured worker during the period he is receiving benefits, and are subject to setoff of certain specified collateral sources, including benefits collectible under workers’ compensation insurance, state temporary disability benefits, Medicare, and benefits collected under federal law by military personnel. Income continuation benefits continue for as long as the injured person is disabled from working because of the injuries, or until the benefit ceiling is exhausted. In the event of a worker’s death, the full benefit amount is payable at once.

Essential services benefits:

The Act provides for the payment of essential service benefits to an injured person to be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family, and members of the family residing in the household, subject to a limit of \$12.00 per day, with a maximum limit of \$4,380 on account of injury to any one person in any one accident. The statute permits a recovery of either \$12.00 a day for each day of the disability, whether or not payment for services was made on a daily basis, or \$4,380 for the total period of the disability, whichever is less. Ordinarily, an injured person can recover for essential services benefits only by way of reimbursement for actual expenditures to a third person rendering services that had been provided by the injured person prior to incapacitation. Thus, normally, an injured person must prove that he or she actually paid someone to perform the services on his or her behalf.

Death benefits:

In the event of the death of an eligible person, two types of lump-sum death benefits are available. First, if the decedent was an income producer, his survivors are entitled to payment of the maximum benefit the income producer himself would have been entitled to for income continuation benefits, i.e., normally \$5,200. Secondly, when the decedent provided essential services, his survivors are entitled to payment of the maximum essential service benefit, normally \$4,380. Neither benefit depends upon proof of actual loss of income or actual cost incurred by the survivors. Thus, all that is required to collect death benefits is proof of the death of an eligible decedent, i.e., one who was in fact an income producer and one who was in fact providing essential services.

Funeral expenses:

The estate of an eligible decedent who dies as a result of injuries sustained in an automobile accident is entitled to actual expenses of any funeral, burial, or cremation up to a maximum benefit of \$1,000.

With respect to these additional classes of benefits, please note that an insured may choose to purchase additional optional benefits, i.e., increased maximum levels of income continuation, essential service, and death benefits.

Eligibility for PIP benefits:

There are three prerequisites to a successful claim for PIP benefits under an automobile policy. First, there must be a policy providing PIP benefits that is valid as to the individual making the claim. Second, the claimant must be a member of one of the classes intended to receive benefits under the PIP statute, and third, the claimant must be able to show legal causation, i.e., that he or she suffered bodily injuries in an accident having a substantial nexus to the use or operation of a qualifying automobile.

A. Coverage classes:

The PIP statute requires automobile insurers to provide PIP benefits for the following: (1) to the named insured and members of his family residing in his household who sustained bodily injury while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile; (2) to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of a named insured, with the permission of the named insured. A “named insured” is defined as not only the person identified as a named insured on the policy, but also his or her spouse, if the spouse is named as a resident of the same household.

B. The “automobile” requirement:

With only two limited exceptions (very limited extended medical benefits, and PIP-type medical benefits for certain bus passengers), PIP benefits are available only if the injured person is “occupying, entering into, alighting from or using” a qualifying “automobile” or is an insured pedestrian struck by an automobile. The term “automobile” is defined by the statute as meaning “a private passenger automobile of a private passenger or station wagon type that is owned or hired and is neither used as a public or livery conveyance for passengers nor rented to others with a driver; and a motor vehicle with a pickup body, a delivery sedan, a van, or a panel truck or a camper type vehicle used for recreational purposes owned by an individual or by husband and wife who are residents of the same household, not customarily used in the occupation, profession or business of the insured other than farming or ranching. An automobile owned by a farm family co-partnership or corporation, which is primarily garaged on a farm or ranch and otherwise meets the definitions of automobile, shall be considered a private passenger automobile owned by two or more relatives resident in the same household.”

In other words, when the vehicle is a traditional passenger sedan or a station wagon, that alone, not its use, determines the insured's eligibility for PIP benefits. The only uses that preclude PIP coverages for such a car are those expressly set out in the statute. Unlike the rule for pickup trucks, vans, panel trucks and the like, there is no overall distinction between cars used in commerce and those used only for personal transportation. The commercial/personal use distinction is irrelevant for passenger sedans or station wagons, unless they are used as a public or livery conveyance for passengers or rented to others with a driver, e.g., a taxicab. Dune buggies and motorcycles are never eligible for PIP benefits. While buses in general are not regarded as "automobiles" for PIP benefits, a 1991 amendment to the Act made eligible passengers on certain specified private buses. Passengers on school buses are not eligible for PIP benefits.

C. Exclusions from coverage:

The PIP Act, specifically N.J.S.A. 39:6A-7 provides a number of specific exclusions to PIP benefits, based upon the conduct of the claimant. If a claimant's conduct contributed to his death or injury while committing a high misdemeanor or felony, or occurred while the claimant was seeking to avoid lawful apprehension or arrest by a police officer, or occurred while the claimant was acting with a specific intent of causing injury or damage to himself or others, then he is excluded from PIP coverage. Additionally, if the claimant was the owner of an automobile required to maintain PIP coverage, which was uninsured at the time of the accident, he is excluded. Finally, if the claimant was occupying or operating an automobile without the permission of the owner or other named insured, they are excluded from PIP coverage.

D. Primacy of coverage:

The PIP statute, specifically N.J.S.A. 39:6A-4.2, provides that the PIP coverage of the named insured shall be the primary PIP coverage for the named insured and any resident relative in the named insured's household who is not a named insured under an automobile policy of his or her own. Therefore, the claimant must first look to his own insurance policy, if he has one. If he does not, he then looks to the policy of a resident family member. If there is no such policy, the claimant can then look to the auto policy which covered the vehicle he was operating or occupying.

What can a medical provider charge/be reimbursed?:

A 1990 amendment to the Act required the New Jersey Commissioner of Insurance to promulgate regulations setting out maximum fees providers could be reimbursed for certain medical procedures/services. This led to the creation of the New Jersey Fee Schedule, which is based on the reasonable and prevailing charges of 75% of the providers in a certain region of the state.

The New Jersey Fee Schedule is set out at N.J.A.C. 11:3-29.4. The amount that a provider can be reimbursed for a certain charge is broken down into three different regions of the state. Certain medical procedures are given "CPT" codes based on the American Medical Association's current procedural terminology coding system. Some procedure's CPT codes are listed on the New

Jersey Fee Schedule, some are not. If a given procedure is listed on the fee schedule, the amount payable is the amount listed for that CPT code for the provider's region in the state. For procedures whose CPT codes are not listed within the New Jersey Fee Schedule, the Act provides that the insured's limit of liability "shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided for, in the case of elective services or equipment provided outside the state, the region in which the insured resides. Where the fee schedule does not contain a reference to similar services or equipment, the insurer's limit of liability for any medical expense benefit for any service of equipment not set forth in the fee schedule shall not exceed the usual, customary, and reasonable fee." The provider's "usual, customary and reasonable fee" is determined by the medical provider.

The regulations provided for reductions for multiple and bilateral procedures performed on the same patient by the same provider at the same time or during the same visit. The primary procedure is paid at 100% of the eligible charge, the second procedure at no more than 50% of the eligible charge, and any additional procedures at no more than 25% of the eligible charge. The regulation provides a daily maximum \$90.00 per day cap on certain physical medicine and rehabilitation CPT codes which are listed in an appendix to the regulation.

Pre-certification/decision point review:

Under the AICRA Act, the treatment for certain soft tissue injuries to the spine and back are subject to designated "care paths", i.e., standard courses of medically necessary treatment. The care paths are set out in an appendix to the N.J.A.C. Regulations. The care paths do not apply to emergency treatment. Care path No. 1 deals with cervical strains and sprains. Care path No. 2 deals with the treatment of cervical herniated discs or radiculopathy. Care path No. 3 deals with treatment of thoracic strains and sprains. Care path 4 deals with the treatment of thoracic herniations or radiculopathy. Care path 5 deals with strains and sprains of the low back, and care path 6 deals with the treatment of lumbar herniations or radiculopathy. The care paths provide charts showing the recommended course of treatment, e.g., conservative therapy of up to four weeks, diagnostic tests depending upon the symptoms, etc. The regulations provide for "decision points" at different points in the treatment care paths. A medical provider must give the PIP carrier notice when a decision point is reached, and must supply a proposed treatment plan requesting further treatment. The company can then have its designated physician review and approve additional treatment, refuse to authorize additional treatment, or schedule an independent medical examination if the records alone are insufficient to approve or deny the proposed treatment plan.

The Administrative Code permits the PIP carrier to require pre-certification of certain medical procedures. To require pre-certification, the company must have submitted to the New Jersey Commissioner of Insurance a Decision Point Review/Pre-certification plan for approval. The company must give the claimant and his medical providers notice of the pre-certification requirements, and the medical providers must then request pre-certification of the procedures or treatment which require pre-certification. The regulations permit the carrier to deduct a 50% penalty for medical expenses that are not pre-certified as required.

Notice of claim - when must the company begin paying benefits?:

The PIP statute, specifically N.J.S.A. 39:6A-5, provides that the insurance company “may require written notice as soon as practicable after an accident.” No set time deadline is provided by the statute. Practically, if the company receives a medical bill that on its face indicates that it is for medical treatment to an insured as a result of a car accident, the claimant has complied with the notice requirement. As a general rule, when the Company receives notice of an accident, the Company will send the insured claimant a PIP Application to be completed and returned. The PIP application will seek information to confirm residency, relation to the named insured, the date and happening of the accident, the injuries sustained, and the identity of medical providers already seen. A treatment provider (not including hospitals or some other listed types of providers) must provide “notice of commencement of treatment” to the company, within 21 days of the first office visit with that provider. If the provider gives late notice, the company is entitled to reduce the amount payable by anywhere from 10% (if notice is received 22 to 30 days after commencement of treatment), all the way up to 100% (if notice of commencement of treatment is provided more than 161 days after commencement of treatment).

The PIP carrier must pay an eligible bill within 60 days of receipt, although the company has the right to request a 45 day extension, if needed. If a bill is not paid within that time frame, the company can be subject to an interest charge.

Resolution of disputes:

If an insured or medical provider seeks the recovery of bills which were denied or “underpaid”, or seeks to compel the company to authorize treatment which was not authorized, the PIP statute permits either side to choose either binding arbitration, or the filing of a lawsuit with the New Jersey Superior Court. Some insurance companies’ PIP endorsements first require a provider to seek review of the decision by way of the Company’s internal appeal process. If a provider who has notice of the Company’s internal appeal process fails to utilize that process, that failure can be a total defense to a subsequent arbitration or lawsuit claim. Some companies’ PIP endorsements then limit dispute resolution to binding arbitration. The PIP statute required the Commissioner of Insurance to designate an organization to serve as the state’s dispute resolution organization for PIP claims. The current organization so designated is National Arbitration Forums. National Arbitration Forums employs full-time, professional arbitrators, i.e., “dispute resolution professionals.” There is a \$225.00 filing fee for a Demand for Arbitration filed with National Arbitration Forums. Upon the filing of a Demand for Arbitration, NAF will appoint a dispute resolution professional, and will schedule a hearing generally anywhere from four to six months from the filing date. The right to discovery is more circumscribed than the full discovery rights in Superior Court actions. The DRP’s will award costs and reasonable attorney’s fees to a successful claimant. NAF awards are binding, subject to a right to appeal to a three member DRP panel, if an award was “incorrect as a matter of law.”

When disputes are filed by way of lawsuits with the New Jersey Superior Court, the regular Court rules as to discovery apply. Lawsuits generally take much longer to reach the trial stage, and trial court awards of counsel fees generally tend to be much higher than counsel fees awarded by NAF arbitrators. Whenever a claim is made against the company by lawsuit, it is our recommendation that a motion be filed to ask the court to dismiss the Complaint and compel arbitration with NAF.

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