

**CHAPTER 3**

**AUTOMOBILE INSURANCE**

**Authority**

N.J.S.A. 17:1C-6(e) and 17:1-8.1.

**Source and Effective Date**

R.2001 d.44, effective January 4, 2001.  
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 3, Automobile Insurance, expires on January 4, 2006.

**Chapter Historical Note**

Chapter 3, New Jersey Automobile Insurance Plan, was adopted as R.1972 d.20, effective January 31, 1972. See: 3 N.J.R. 223(d), 4 N.J.R. 49(d).

Subchapter 7, Automobile Repair Reform Act, was adopted as R.1972 d.244, effective December 4, 1972. See: 4 N.J.R. 270(a), 5 N.J.R. 13(c).

Subchapter 10, Auto Physical Damage Claims, was adopted as R.1976 d.46 and R.1976 d.47, effective May 1, 1976. See: 8 N.J.R. 38(b), 8 N.J.R. 136(b).

Pursuant to Executive Order No. 66(1978), Subchapter 8, Nonrenewal of Automobile Insurance Policies, was readopted as R.1983 d.190, effective June 6, 1983. See: 15 N.J.R. 231(a), 15 N.J.R. 927(a).

Subchapter 12, Automobile Rate Filers: Flattening of Premium Taxes and Assessments Made for the Unsatisfied Claim and Judgment Fund, was adopted as R.1983 d.424, effective October 3, 1983. See: 15 N.J.R. 1170(a), 15 N.J.R. 1666(a).

Subchapter 13, Automobile Rate Filers: Deductibles for Private Passenger Automobile Collision and Comprehensive Coverage, was adopted as R.1983 d.467, effective October 17, 1983. See: 15 N.J.R. 1342(a), 15 N.J.R. 1769(b).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Insurance Identification Card, was readopted as R.1983 d.648, effective December 29, 1983. See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Public Notice: Automobile Insurance Written Notice/Buyer's Guide Coverage Selection Form. See: 16 N.J.R. 254(d).

Subchapter 15, Standards for Written Notice: Buyer's Guide and Coverage Selection Form, was adopted as R.1984 d.114, effective April 2, 1984. See: 15 N.J.R. 2142(a), 16 N.J.R. 733(a).

Subchapter 14, Personal Injury Protection Options, was adopted as R.1984 d.116, effective April 2, 1984. See: 15 N.J.R. 2139(a), 16 N.J.R. 730(b).

The Executive Order No. 66(1978) expiration date of Subchapter 7, Automobile Repair Reform Act, was extended by gubernatorial directive from August 17, 1984 to November 15, 1984, and was further extended by gubernatorial directive from November 15, 1984 to February 13, 1985. See: 17 N.J.R. 43(a).

Pursuant to Executive Order No. 66(1978), Subchapter 7, Automobile Repair Reform Act, was readopted as R.1985 d., effective February 13, 1985. See: 17 N.J.R. 43(a), 17 N.J.R. 707(b).

Subchapter 17, Rating Organizations, was adopted as R.1985 d.609, effective October 6, 1985. See: 16 N.J.R. 2936(a), 17 N.J.R. 2905(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1985 d.654, effective January 6, 1986, operative May 6, 1986. See: 16 N.J.R. 3286(a), 17 N.J.R. 89(b).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as R.1986 d.111, effective April 7, 1986. See: 17 N.J.R. 2597(a), 18 N.J.R. 692(a).

Subchapter 17, Rating Organizations, was repealed and Subchapter 17, Rating Organizations, was adopted as new rules by R.1986 d.419, effective October 6, 1986. See: 18 N.J.R. 1171(b), 18 N.J.R. 2045(a).

Subchapter 22, Coverage Option Survey: Personal Injury Protection and Tort Threshold Options, was adopted as R.1986 d.463, effective November 17, 1986. See: 18 N.J.R. 1344(b), 18 N.J.R. 2329(a).

Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, was adopted as R.1987 d.527, effective December 21, 1987. See: 19 N.J.R. 1880(a), 19 N.J.R. 2403(b).

Public Notice: Rescission of Circular Letter #75. See: 19 N.J.R. 570(e).

Subchapter 26, Accident Claims, Subchapter 27, Unsatisfied Claim and Judgment Fund Board, and Subchapter 28, Unsatisfied Claim and Judgment Fund's Reimbursement of Excess Medical Expense Benefits Paid by Insurers, were adopted as R.1989 d.268, effective May 15, 1989. See: 21 N.J.R. 688(a), 21 N.J.R. 1363(a).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was repealed and Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as new rules by R.1989 d.277, effective May 15, 1989. See: 21 N.J.R. 667(b), 21 N.J.R. 1335(a), 21 N.J.R. 1517(b).

Subchapter 24, Policy Constants, and Subchapter 25, Residual Market Equalization Charges (RMECs), were adopted as R.1989 d.278, effective May 15, 1989. See: 20 N.J.R. 3104(a), 21 N.J.R. 1358(b).

Subchapter 20A, Standard Limiting Effect of Negative Excess Investment Income in the Computation of Excess Profits, was adopted as R.1989 d.306, effective June 5, 1989. See: 21 N.J.R. 842(a), 21 N.J.R. 1517(c).

Subchapter 17, Rating Organizations, was repealed by R.1989 d.328, effective June 19, 1989. See: 21 N.J.R. 973(a), 21 N.J.R. 1708(a).

Subchapter 30, Motor Vehicle Self-Insurance, was adopted as R.1989 d.584, effective November 20, 1989. See: 21 N.J.R. 2876(a), 21 N.J.R. 3666(b).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was adopted as R.1990 d.108, effective February 5, 1990. See: 21 N.J.R. 3726(a), 22 N.J.R. 425(a).

Subchapter 18, Private Passenger Automobile Insurance: Rate Filing Review Procedures, was adopted as R.1990 d.109, effective February 5, 1990. See: 21 N.J.R. 3422(b), 22 N.J.R. 421(a).

Subchapter 16, Rate Filing Requirements: Voluntary Market Private Passenger Automobile Insurance, was adopted as R.1990 d.116, effective February 5, 1990. See: 21 N.J.R. 2182(a), 22 N.J.R. 399(a).

Subchapter 1, Provisions and Operations, was repealed and Subchapter 1, Commercial Automobile Insurance Plan, was adopted as new rules by R.1990 d.118, effective February 5, 1990. See: 21 N.J.R. 3613(a), 22 N.J.R. 392(b).

Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, was adopted as R.1990 d.161, effective March 19, 1990. See: 21 N.J.R. 3719(a), 22 N.J.R. 963(a).

Subchapter 34, Eligible Persons Qualifications and Automobile Insurance Eligibility Points Schedule, was adopted as emergency new rules by R.1990 d.620, effective November 26, 1990, operative April 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3847(a). The provisions of R.1990 d.620 were readopted as R.1991 d.93, effective January 25,

1991, operative April 1, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3847(a), 23 N.J.R. 572(a)

Subchapter 36, Automobile Physical Damage Insurance Inspection Procedures, was adopted as emergency new rules by R.1990 d.622, effective November 26, 1990, operative March 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3861(a). The provisions of R.1990 d.622 were readopted as R.1991 d.95, effective January 25, 1991, operative October 1, 1992, with changes effective February 19, 1991. See: 22 N.J.R. 3861(a), 23 N.J.R. 579(a), 23 N.J.R. 1132(c).

Subchapter 38, Towing and Storage Fee Schedule, was adopted as emergency new rules by R.1990 d.623, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3874(a). The provisions of R.1990 d.623 were readopted as R.1991 d.97, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3874(a), 23 N.J.R. 592(a).

Subchapter 29, Medical Fee Schedules: Automobile Insurance Personal Injury Protection Coverage, was adopted as emergency new rules by R.1990 d.624, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3809(a). The provisions of R.1990 d.624 were readopted as R.1991 d.96, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3809(a), 23 N.J.R. 536(a).

Subchapter 37, Order of Benefit Determination Between Automobile Personal Injury Protection and Health Insurance, was adopted as emergency new rules by R.1990 d.625, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3777(a). The provisions of R.1990 d.625 were readopted as R.1991 d.90, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).

Subchapter 35, Private Passenger Automobile Insurance Underwriting Rules, was adopted as emergency new rules by R.1990 d.627, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3856(a). The provisions of R.1990 d.627 were readopted as R.1991 d.94, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3856(a), 23 N.J.R. 577(a).

Subchapter 19, Standard/Non-Standard Rating Plans, was adopted as emergency new rules by R.1990 d.628, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3804(a). The provisions of R.1990 d.628 were readopted as R.1991 d.92, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3804(a), 23 N.J.R. 532(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1991 d.45, effective January 4, 1991, and Subchapters 2 through 5, concerning the Automobile Insurance Plan (AIP), were repealed by R.1991 d.45, effective February 4, 1991. See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Subchapter 24, Policy Constants, was repealed by R.1991 d.216, effective April 15, 1991. See: 22 N.J.R. 3441(a), 23 N.J.R. 1132(a).

Subchapter 25, Residual Market Equalization Charges (RMECs), was repealed by R.1991 d.217, effective April 15, 1991. See: 22 N.J.R. 3442(a), 23 N.J.R. 1132(b).

Subchapter 39, Reductions in Premium Charges for Private Passenger Automobiles Equipped with Anti-Theft, Vehicle Recovery and Safety Features, was adopted as R.1991 d.363, effective July 15, 1991, operative September 1, 1991. See: 23 N.J.R. 384(a), 23 N.J.R. 2144(a).

Subchapter 33, Appeals from Denial of Automobile Insurance, was adopted as R.1992 d.192, effective April 30, 1992. See: 24 N.J.R. 546(a), 24 N.J.R. 1510(a).

Subchapter 40, Insurers Required to Provide Automobile Insurance Coverage to Eligible Persons, was adopted as R.1992 d.207, effective May 4, 1992. See: 23 N.J.R. 3736(a), 24 N.J.R. 336(a), 24 N.J.R. 1796(b).

Subchapter 2, New Jersey Personal Automobile Insurance Plan, was adopted as new rules by R.1992 d.370, effective September 21, 1992. See: 24 N.J.R. 331(a), 24 N.J.R. 3400(a).

Subchapter 3, Limited Assignment Distribution Servicing Carriers, was adopted as new rules by R.1992 d.371, effective September 21, 1992. See: 24 N.J.R. 519(a), 24 N.J.R. 3414(a).

Subchapter 42, Producer Assignment Program, was adopted as emergency new rules by R.1992 d.381, effective September 4, 1992, to expire November 3, 1992. See: 24 N.J.R. 3421(a). The provisions of R.1992 d.381 were readopted as R.1992 d.482, effective November 2, 1992, with changes effective December 7, 1992. See: 24 N.J.R. 3421(a), 24 N.J.R. 4397(a).

Subchapter 44, Special Rules for Effecting Coverage for Private Passenger Automobile Insurance, was adopted as emergency new rules by R.1993 d.135, effective March 1, 1993, operative March 8, 1993, to expire April 30, 1993. See: 25 N.J.R. 1290(a). The provisions of R.1993 d.135 were readopted as R.1993 d.238, effective April 30, 1993. See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

Subchapter 2B, Market Transition Facility of New Jersey Suspension of Claims, was adopted as emergency new rules by R.1994 d.164, effective March 1, 1994, to expire April 30, 1994. See: 26 N.J.R. 1393(a). The provisions of R.1994 d.164 were readopted as R.1994 d.261, effective April 29, 1994. See: 26 N.J.R. 1393(a), 26 N.J.R. 2288(a).

Subchapter 32, Certification of Compliance: Mandatory Liability Coverages, was adopted as R.1994 d.477, effective September 19, 1994. See: 26 N.J.R. 1939(a), 26 N.J.R. 3866(a).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was repealed by R.1995 d.171, effective March 20, 1995. See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

Subchapter 45, Insurers Required to Provide Survey Information, was adopted as R.1995 d.235, effective May 1, 1995. See: 27 N.J.R. 289(a), 27 N.J.R. 1803(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1996 d.58, effective January 4, 1996, and Subchapter 2A, New Jersey Automobile Full Insurance Underwriting Association Claims Payment Deferral, Subchapter 3, Limited Assignment Distribution Servicing Carriers, and Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, were repealed by R.1996 d.58, effective February 5, 1996. See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Subchapter 20A, Standard Limited Effect of Negative Excess Investment Income in the Computation of Excess Profits, was repealed by R.1996 d.312, effective July 15, 1996. See: 28 N.J.R. 1616(a), 28 N.J.R. 3627(b).

Subchapter 25, Private Passenger Automobile Insurance: Notification by Treating Health Care Providers, was adopted as new rules by R.1997 d.14, effective January 6, 1997. See: 28 N.J.R. 3876(a), 29 N.J.R. 132(a).

Subchapter 24, Defensive Driving Rate Reductions, was adopted as new rules by R.1997 d.522, effective December 15, 1997. See: 28 N.J.R. 4854(a), 29 N.J.R. 5305(a).

Subchapter 28A, Unsatisfied Claim and Judgment Fund Assessments, was adopted as R.1997 d.535, effective December 15, 1997. See: 29 N.J.R. 4246(a), 29 N.J.R. 5309(a).

Subchapter 19A, Tier Rating Plans and Underwriting Rules, was adopted as R.1998 d.129, effective March 2, 1998. See: 29 N.J.R. 5253(a), 30 N.J.R. 839(a).

Subchapter 46, Automobile Insurance Urban Enterprise Zone Program, was adopted as R.1998 d.290, effective June 1, 1998. See: 30 N.J.R. 773(a), 30 N.J.R. 2010(a).

Subchapter 3, Basic Automobile Insurance Policy, was adopted as new rules by R.1998 d.592, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3209(a), 30 N.J.R. 4398(a).

Subchapter 5, Personal Injury Protection Dispute Resolution, was adopted as new rules by R.1998 d.593, effective December 21, 1998. See: 30 N.J.R. 3359(a), 30 N.J.R. 4437(a).

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Subchapter 4, Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests, was adopted as new rules by R.1998 d.597, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3211(a), 30 N.J.R. 3748(a), 30 N.J.R. 4401(a).

Subchapter 38, Towing and Storage Fee Schedule, was repealed by R.1999 d.1, effective January 4, 1999. See: 30 N.J.R. 2813(a), 31 N.J.R. 54(c).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.2001 d.44, effective January 4, 2001, and Subchapter 2B, Market Transition Facility of New Jersey Payment Prioritization and Claims Payment Deferral, Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, Subchapter 19, Standard/Nonstandard Rating Plans, and Subchapter 42, Producer Assignment Program, were repealed by R.2001 d.44, effective February 5, 2001. See: Source and Effective Date. See, also, section annotations.

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#### SUBCHAPTER 1. COMMERCIAL AUTOMOBILE INSURANCE PLAN

##### 11:3-1.1 Purpose and scope

(a) The purpose of this subchapter is to establish a plan pursuant to N.J.S.A. 17:29D-1:

1. To provide the coverages described herein, subject to the conditions stated, for motor vehicles other than those vehicles subject to the New Jersey Personal Automobile Insurance Plan and any other private passenger vehicle that is owned by or driven by a person who meets the definition of an eligible person pursuant to N.J.S.A. 17:33B-13 and N.J.A.C. 11:3-34;

2. To provide for the apportionment of insurance coverage for qualified applicants who are in good faith entitled to but are unable to procure the same, through the voluntary market; and

3. To establish a procedure for the sharing of premiums, losses, and expenses among all insurers who are participants in New Jersey as defined within this subchapter for all risks qualified for coverage under the provisions of this subchapter.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

In (a), inserted "other" preceding "private passenger vehicle" in 1, substituted "qualified" for "eligible" preceding "applicants" in 2 and substituted "qualified" for "eligible" preceding "for coverage" in 3.

##### 11:3-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"CAIP" or "Plan" means the Commercial Automobile Insurance Plan pursuant to this subchapter.

“CAIP manager” means the entity employed by the Governing Committee to manage and conduct the administrative affairs of the CAIP on a daily basis.

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Emergency type vehicle” means any land vehicle, used to respond to distress calls, fires, or rescue, propelled by other than muscular power and not run upon rails or tracks. This term includes, but is not limited to, fire trucks, rescue trucks, police cars and ambulances.

“Gross participation” means a participant’s Voluntary All Other Automobile Direct Written Premiums derived from information contained in the annual statement times a fraction, the numerator of which is the sum of the plan’s total written premiums for that year and the Statewide total Voluntary All Other Automobile Direct Written Premiums which are eligible for depopulation credit for that policy year, and the denominator of which is the Statewide total Voluntary All Other Automobile Net Direct Written Premiums of all participants for that second prior year.

“Light truck” means a vehicle with a gross vehicle weight (G.V.W.) of 10,000 pounds or less.

“Motor vehicle” means any land vehicle propelled otherwise than by muscular power including trailers and semi-trailers, except such vehicles that run only upon rails or tracks.

“Net participation” means a participant’s gross participation for that policy year less its business eligible for depopulation credit for that policy year.

“Net participation percentage” means a participant’s net participation for that policy year in proportion to the comparable Statewide total net participation for all participants.

“Operating headquarters” means the chief place of business where the principal officers generally transact business, and the place to which reports are made and from which orders emanate. It is the location where the executive offices are, corporate decisions are made and corporate functions are performed.

“Participant” means an insurer licensed and authorized to write motor vehicle liability or physical damage insurance and specifically includes any insurer who writes all other automobile liability and all other automobile physical damage insurance.

“Personal injury protection” means those benefits as set forth at N.J.S.A. 39:6A-4.

“Policy year” means the exposure and premiums for all policies written during a calendar year and all losses attributable to policies written during the same calendar year.

“Private passenger automobile” means a vehicle that meets the definition in N.J.S.A. 39:6A-2a, that is not eligible for coverage through any voluntary or residual market mechanism created by statute, and is owned by an individual or husband and wife; or owned jointly by two or more relatives other than husband and wife; or owned jointly by two or more resident individuals; or owned by a corporation, partnership or unincorporated association, governmental agency, or registered to a professional designation (that is, T/A, PA or P.C.) where such automobiles are furnished to individuals and are not used for business purposes.

“Private passenger type automobile” means a vehicle that meets the definition in N.J.S.A. 39:6A-2a and is owned by a corporation, partnership or any other entity except an individual or husband and wife and used for business purposes.

“Qualified applicant” means the owner or registrant of a motor vehicle registered in New Jersey or to be registered within 60 days who is unable to obtain automobile insurance in New Jersey in the voluntary market and is not in good faith qualified for automobile insurance coverage in any residual market mechanism created by statute other than the CAIP. For multi-state operations, the applicant must have its operating headquarters in New Jersey but vehicles may be registered in other states. No applicant shall be deemed qualified if the principal operator of the vehicle to be insured does not hold a driver’s license which is valid in New Jersey, or if a regular operator of the vehicle other than the principal operator does not hold such a license.

“Voluntary All Other Automobile Direct Written Premiums” means automobile liability, personal injury protection, and physical damage premiums written by a participant on New Jersey risks, minus:

1. CAIP direct written premiums included in the figures which the participant wrote as a service carrier for CAIP;
2. Any direct written premiums included in the figures from insureds who are qualified applicants for any residual market mechanism created by statute other than the CAIP;
3. Any reinsurance premiums assumed from other insurers included in the figures;
4. Any premiums for Death and Disability coverage included in the figures;
5. Private passenger nonfleet automobile bodily injury and property damage liability, medical payments, basic and additional personal injury protection, and uninsured and underinsured motorists voluntary premium;
6. Miscellaneous nonfleet specialty personal automobile bodily injury and property damage liability voluntary premiums for any class approved by the Department as specified in the plan of operation; and

7. Taxi bodily injury, property damage liability, uninsured and underinsured motorists and physical damage premiums.

Amended by R.1991 d.45, effective February 4, 1991.  
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Deleted definition of NJAFIUA and references to it; added text to definitions for "Private passenger automobile" and "Voluntary All Other Automobile Direct Written Premiums."

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Inserted "Personal injury protection".

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

1. The plan shall include procedures for the injured person or his or her designee to provide prior notice to the insurer or its designee together with the appropriate clinically supported findings that additional treatment or the administration of a test in accordance with N.J.A.C. 11:3-4.5(b) is medically necessary, as follows:

i. The prompt review of the notice and supporting materials submitted by the provider and authorization or denial of reimbursement for further treatment or tests;

ii. The scheduling of a physical examination of the injured person in accordance with (b)2 below where the notice and supporting materials and other medical records if requested, are not sufficient to authorize or deny reimbursement of further treatment or tests; and

iii. Any denial of reimbursement for further treatment or tests shall be based on the determination of a physician.

2. A physical examination of the injured party as part of a decision point review shall be conducted as follows:

i. The insurer shall notify the injured person or his or her designee that a physical examination is required;

ii. The physical examination shall be scheduled within seven calendar days of receipt of the notice in (b)1 above unless the injured person agrees to extend the time period;

iii. The medical examination shall be conducted by a provider in the same discipline as the treating provider;

iv. The medical examination shall be conducted at a location reasonably convenient to the injured person;

v. The treating provider or injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided no later than the time of the examination; and

vi. The insurer shall notify the injured person or his or her designee whether reimbursement for further treatment or tests is authorized as promptly as possible but in no case later than three days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

3. The plan may provide that failure to notify the insurer as required in the plan; failure to provide medical records; or failure to appear for the physical examination scheduled in accordance with b(2) above shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical goods and non-medical expenses that are incurred after notification to the

insurer is required but before authorization for continued treatment or the administration of a test is made by the insurer. No insurer may impose the additional co-payment where the insurer received the required notice but failed to act in accordance with its approved decision point plan to authorize or deny reimbursement of further treatment or tests.

4. The plan shall avoid undue interruptions in a course of treatment.

5. Insurers are encouraged to provide decision point review plans that permit the treating provider to submit for review a comprehensive treatment plan so as to minimize the need for piecemeal review.

(c) All decision point review plans, including a pre-certification program filed and approved pursuant to N.J.A.C. 11:3-4.8 shall contain provisions for the disclosure of the procedures in the decision point review plan to injured persons and providers.

1. The information required to be disclosed pursuant to this subsection shall include a description of:

i. The financial responsibility of the injured person including co-payments and deductibles;

ii. The financial responsibility of the provider for providing treatment or administering tests without authorization from the insurer; and

iii. How authorization for treatment and the administration of tests may be obtained.

2. In addition to the description of the plan set forth in the policy form, the insurer shall provide any information necessary to comply with decision point review in accordance with this rule to the injured person, the provider, or both, promptly upon receiving notice of the claim.

(d) No decision point requirements shall apply within 10 days of the insured event. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

Amended by R.2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

Deleted a former (c); and recodified former (d) and (e) as (c) and (d).

### 11:3-4.8 Precertification

(a) Insurers may require precertification of certain specific medical procedures, treatments, diagnostic tests, other services and durable medical equipment that are not subject to decision point review and that may be subject to overutilization.

(b) Precertification requirements shall be included with a decision point review plan submission but the medical procedures, treatments, diagnostic tests, durable medical equipment or other services that require precertification shall be identified separately from decision point review.

(c) No precertification requirements shall apply within 10 days of the insured event.

(d) Precertification shall be based exclusively on medical necessity and shall not encourage over or under utilization of the treatment or test.

(e) An insurer that wishes to use precertification shall designate a licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that:

1. Any utilization decision to deny reimbursement for further testing or treatment because the treatment or diagnostic tests are not medically necessary, shall be made by a physician. In the case of treatment prescribed or provided by a dentist, the decision shall be by a dentist;

2. A utilization management decision shall not retroactively deny payment for treatment provided when prior approval has been obtained, unless the approval was based upon fraudulent information submitted by the person receiving treatment or the provider; and

3. The utilization management program shall be available, at a minimum, during normal working hours to respond to authorization requests.

(f) The insurer shall include precertification requirements in the information about its decision point review plan that will be given to consumers with new and renewal policies and upon notice of a claim. The consumer information shall include at a minimum the items in N.J.A.C. 11:3-4.7(d).

(g) A precertification plan may include provisions that require injured persons to obtain durable medical equipment directly from the insurer or its designee.

(h) Policy forms may include an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with precertification requirements.

(i) Precertification shall avoid undue interruptions in a course of treatment.

(j) Insurers are encouraged to permit a treating provider to submit a comprehensive treatment plan for precertification so as to minimize the need for piecemeal review.

Amended by R.2000 d.454, effective November 6, 2000.  
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).  
Rewrote the section.

### 11:3-4.9 Assignment of benefits; public information

(a) Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.

(b) An insurer shall identify documents containing proprietary information in its decision point review plan submission. Documents containing proprietary information shall be confidential and shall not be subject to public inspection and copying pursuant to the "Right-to-Know" law, N.J.S.A. 47:1A-1 et seq. The Department shall notify the insurer prior to responding to any public record request for proprietary information.

Amended by R.2000 d.454, effective November 6, 2000.  
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).  
Designated existing section as (a) and added (b).

### 11:3-4.10 Reporting requirements

(a) Insurers shall file with the Department a completed quarterly decision point review/precertification report (Appendix Exhibit 11, incorporated herein by reference). The report shall be due no later than the last day of the calendar month following the evaluation dates of December 31, March 31, June 30 and September 30.

(b) The report shall be compiled on a group basis and shall be submitted using the Excel spreadsheet template in the Exhibit. The template shall not be modified in any way. The template spreadsheet is available on the Department's website at: [http://www.state.nj.us/dobi/pn99\\_477.xls](http://www.state.nj.us/dobi/pn99_477.xls). The report shall be filed on diskette, by e-mail (the preferred method) or CD-ROM. The report shall contain a contact name, phone number and mailing address. The filing shall be e-mailed to [reports@dobi.state.nj.us](mailto:reports@dobi.state.nj.us) or mailed to:

New Jersey Department of Banking and Insurance  
Office of Property and Casualty  
PO Box 325  
Trenton, NJ 08625-0325

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New Rule, R.2000 d.454, effective November 6, 2000.  
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).  
Amended by R.2003 d.3, effective January 6, 2003.  
See: 34 N.J.R. 2518(a), 35 N.J.R. 249(b).  
Rewrote (a) and (b).

### APPENDIX

#### TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATHS

##### Exhibit 1

##### Glossary of Terms

Acute Disease—a disease with rapid onset and short course to recovery. Not chronic.

Care Path—a recommended extensive course of care based on professionally recognized standards.

**Case Management**—a method of coordinating the provision of healthcare to persons injured in automobile accidents, with the goal of ensuring continuity and quality of care and cost effective outcomes. The Case Manager may be a nurse, social worker, or physician, preferably with certification in case management.

**Cauda Equina**—a collection of spinal roots that descend from the lower part of the spinal cord. They exist in the lower part of the vertebral canal.

**Chronic Disease**—a disease with long duration that changes little and progresses slowly. The opposite of acute.

**Clinical Evaluation**—the evaluation of the symptoms and signs of an injured person by a treating practitioner.

**Conservative Therapy**—treatment which is not considered aggressive; avoiding the administration of medicine or utilization of invasive procedures until such procedures are clearly indicated.

**Contusion**—an injury to underlying soft tissues when the skin is not broken. A bruise.

**Diagnostic Evaluation**—the process of differentiating between two or more diseases with similar signs and symptoms through the use of evaluative procedures such as imaging, laboratory, and physical tests.

**Herniation**—the protrusion or projection of an organ or other body structure through a defect or natural opening in a covering membrane, muscle, or bone.

**Independent Consultative Opinion**—physical examination by a physician of similar specialty to the injured person's treating practitioner to provide a second medical opinion. The independent physician may support, refute, or provide alternatives to the current diagnosis and treatment plans.

**Non-Compliant**—a patient who wilfully chooses not to participate in the treatment plan agreed upon by the patient and his/her healthcare provider and does not have secondary issues such as lack of transportation, pre-existing conditions or comorbidities.

**PT—Physical Therapy**—the therapeutic use of heat, light, water, electricity, massage, exercise, and non-ionizing radiation in treatment of injuries to the soft tissue and muscles/skeleton. PT rendered to persons injured in automobile accidents must be provided by a person whose scope of licensure includes physical therapy.

**Radicular**—pertaining to a root (such as a nerve root) disorder.

**Radiculopathy**—a disorder of a nerve root.

**Sign**—an objective manifestation, usually indicative of a disease or disorder. Signs can be observed by the clinician, as opposed to symptoms, which are perceived only by the affected individual.

**Soft Tissue Injury**—injuries sustained to the muscle, skin, connective tissue.

**Spine**—the vertebral column.

**Spinal Shock**—an acute condition resulting from spinal cord severance. Characterized by a total sensory loss and loss of reflexes below the level of injury and flaccid paralysis.

**Sprain**—an injury at a joint where a ligament is stretched or torn.

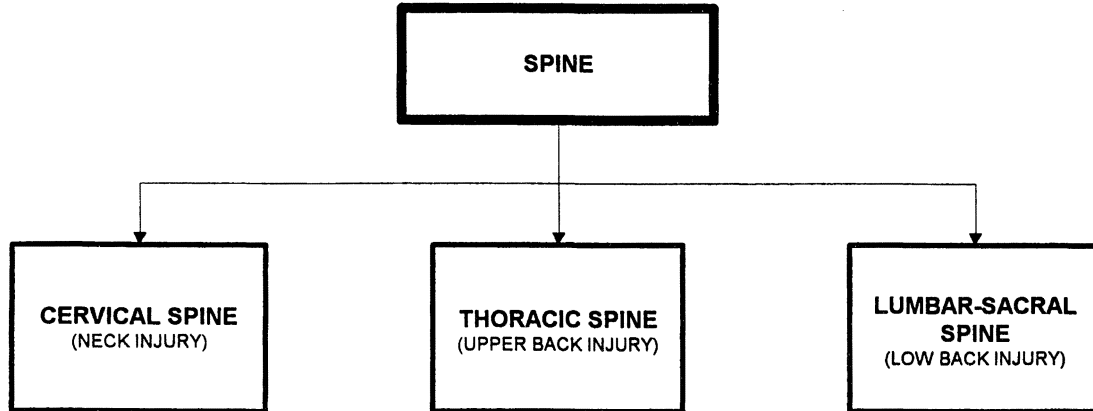
**Strain**—an injury caused by the over-stretching or tearing of a muscle or tendon. In its most severe form, the muscle ruptures.

**Symptom**—a subjective manifestation, usually indicative of a disease or disorder. Symptoms are experienced only by the affected individual, as opposed to signs, which can be observed by others.

**Treatment Plan**—specific medical, surgical, chiropractic, acupuncture, or psychiatric procedures used to improve the signs or symptoms associated with injuries sustained in automobile accidents, e.g., physical therapy, surgery, administration of medications, etc.

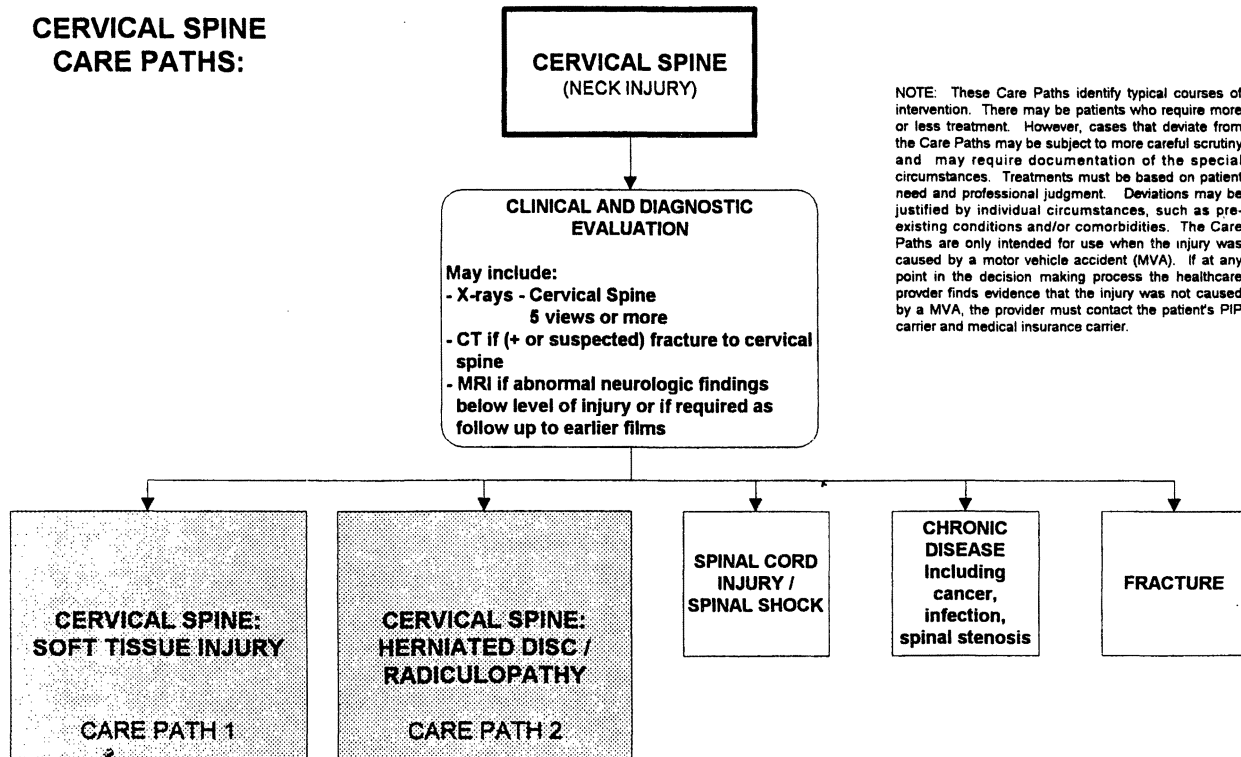
EXHIBIT 2

**TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATH OVERVIEW**



The following flow charts address the three anatomical areas of spinal injuries; Care Paths 1 through 6 have been developed for the conditions noted in the shaded boxes.

**CERVICAL SPINE CARE PATHS:**



NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

6. The plan shall provide for the fair and efficient conduct of adversarial hearings when other methods of dispute resolution are either unsuccessful or inappropriate, consistent with traditional notions of due process and fundamental fairness. It shall address, at least, the following procedural issues;

- i. Discovery;
- ii. Receipt of evidence by the dispute resolution professional;
- iii. Submission of briefs or memoranda of law and fact;
- iv. Provision for decisions without testimony on consent of parties;
- v. Notice and place of hearing;
- vi. Methods to request adjournments;
- vii. Presentation of testimony and evidence at a hearing; and
- viii. Supplementation of the record.

(c) If consistent with its dispute resolution plan, a dispute resolution organization may utilize one or more dispute resolution professionals specifically to handle preliminary matters on actions including motions to disqualify an appointed DRP.

#### 11:3-5.5 Dispute resolution professionals

(a) A dispute resolution professional employed by the dispute resolution organization shall be either:

1. An attorney licensed to practice in New Jersey with at least 10 years' experience in cases involving personal injury or workers' compensation;
2. A former judge of the Superior Court or the Workers' Compensation Court, or a former Administrative Law Judge; or
3. Any other person, qualified by education and at least 10 years' experience, with sufficient understanding of automobile insurance claims and practices, contract law, and judicial or alternate dispute resolution practices and procedures.

(b) Dispute resolution professionals shall avoid conflicts of interest as prohibited at N.J.A.C. 11:3-5.12 in any matter assigned to them for determination.

1. Dispute resolution professionals shall complete and file with the dispute resolution organization a conflict of interest questionnaire that shall provide sufficient detail about financial interests of themselves and their immediate family so as to avoid any assignment to a particular case where there is a conflict of interest. Conflict of interest questionnaires shall remain confidential with the dispute resolution organization, and the information set forth therein shall only be disclosed as necessary to

individuals responsible for assigning cases to dispute resolution professionals, or reviewing motions to disqualify an assigned dispute resolution professional.

2. If during the course of an assignment a dispute resolution professional determines that he or she has conflict of interest, based upon facts determined in the course of the proceedings, then the DRP shall promptly advise the administrator of the circumstances, who shall assign another DRP.

3. A party may challenge the assignment of a particular DRP by submitting the specific grounds for challenge in accordance with the rules of the dispute resolution organization approved by the Commissioner.

(c) Dispute resolution professionals shall be compensated by the administrator in accordance with the terms of the contract designating the administrator. Compensation shall not be contingent in any way upon the decision or determination of the DRP.

(d) Dispute resolution professionals shall create and maintain such records as may be necessary to carry out their responsibilities and provide such records to the administrator as required in the contract designating the administrator.

#### 11:3-5.6 Conduct of PIP dispute resolution proceedings

(a) A request for dispute resolution of a PIP dispute may be made by the injured party, the insured, a provider who is an assignee of PIP benefits or the insurer, in accordance with the terms of the policy as approved by the Commissioner. The request for dispute resolution may include a request for review by a medical review organization. The request shall be made to the administrator and copies sent to other parties.

(b) Upon receipt of the request, the administrator shall promptly assign the matter to dispute resolution professional. The administrator shall notify all parties of the DRP assigned.

(c) If the request for dispute resolution includes a request for review by a medical review organization, the administrator shall refer the matter to a certified medical review organization contemporaneously with the assignment of the DRP, and shall notify the parties and the DRP that the matter has been referred. If the initial request does not include a request for review by a medical review organization, then a request for such review may be made by any party to the assigned DRP. The DRP may refer a matter to a MRO on his or her own initiative upon a finding that the dispute concerns the diagnosis, medical necessity of treatment or diagnostic test administered to the injured person, whether the injury is causally related to the accident or is the product of a preexisting condition, or the protocols utilized by a provider. Whenever a DRP receives or initiates a request for MRO review, he or she shall transmit it to the administrator for referral who shall refer the matter to a

certified MRO and notify the parties that the matter has been referred.

1. The administrator shall refer cases on a random or rotating basis to an MRO that does not have a conflict of interest, in accordance with the administrator's dispute resolution plan. Referrals shall be made in such a manner so as not to disclose the medical reviewer the identity of the insurer, nor to disclose to the insurer the identity of the medical reviewer.

2. Upon request of the MRO, a provider whose services are the subject of review shall promptly furnish a written report of the history, condition, treatment dates and results of diagnostic tests performed, and shall produce and permit the copying and inspection of all records relating to the history, treatment and condition of the injured person, and shall submit all necessary documentation as requested. Upon request of the MRO through the administrator, the insurer shall submit any and all documentation concerning its review of the treatment and testing of the injured person, and any reports by its reviewing provider why reimbursement for the treatment, test or item of durable medical equipment was denied.

3. The MRO may request an injured person to submit to a mental or physical examination by an independent provider in the same discipline as the treating providers who is not affiliated with either the treating provider, the insurer or the MRO health care provider performing the review. Any such examination shall be conducted in a place reasonably convenient to the injured person. The MRO shall make available to the examining provider any pertinent medical records.

4. If at any time the MRO determines that it has a conflict of interest in performing a particular review, it shall notify the administrator which shall refer the case to another MRO.

i. Under such circumstances, the first-assigned MRO shall transmit to the newly assigned MRO such documents from the treating provider and the insurer as it has accumulated on the case, as may be directed by the administrator.

ii. The first-assigned MRO shall not be entitled to any reimbursement for work performed on the transferred case.

(d) Determination by the dispute resolution professional shall be in writing and shall state the issues in dispute, the DRP's findings and legal conclusions based on the record of the proceedings and the determination of the medical review organization, if any. The findings and conclusions shall be made in accordance with applicable principles of substantive law, the provisions of the policy and the Department's rules. The award shall set forth a decision on all issues submitted by the parties for resolution.

1. If the DRP finds that the determination of a medical review organization is overcome by a preponderance of the evidence, the reasons supporting that finding shall be set forth in the written determination.

2. The award shall apportion the costs of the proceedings, regardless of who initiated the proceedings, in a reasonable and equitable manner consistent with the resolution of the issues in dispute.

3. The award may include attorney's fees for a successful claimant in an amount consonant with the award and with Rule 1.5 of the Supreme Court's Rules of Professional Conduct.

(e) The award shall be signed by the dispute resolution professional. The original shall be filed with the administrator, and copies provided to each party. If the award requires payment by the insurer for a treatment or test, payment shall be made, together with any accrued interest pursuant to N.J.S.A. 39:6A-5, within 20 days of receipt of a copy of the determination.

(f) The final determination of the dispute resolution professional shall be binding upon the parties, but subject to vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A. 2A:23A-13 for review of the award.

Amended by R.2000 d.454, effective November 6, 2000.

See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).

In (d)3, deleted "or respondent" following "successful claimant".

#### Case Notes

N.J.A.C. 11:3-5.6(d)(3) was an invalid expression of legislative intent and was voided. *New Jersey Coalition of Health Care Professionals, Inc. v. New Jersey Department of Banking and Insurance, Division of Insurance*, 323 N.J.Super. 207, 732 A.2d 1063 (N.J.Super.A.D. 1999).

#### 11:3-5.7 Recordkeeping

(a) The administrator shall maintain records of all determinations for a period of five years.

(b) The administrator shall file a copy of each determination, except consent determinations, with the Department in either hard copy or electronic form, as provided in the contract designating the administrator.

1. Any determination filed with the Department shall be indexed and coded so as to facilitate retrieval.

2. The name of any injured party, except when appearing in the caption of the matter or used as identification of the particular case, shall be redacted in the copy filed with the Department so as to protect the privacy of the injured person.

(c) The administrator shall keep such other records as may be required by the Commissioner and as set forth in the contract designating the administrator.

1. The completion of a defensive driving course that appears on the driver record abstract. All drivers who have taken an approved defensive driving course will have the date the course was actually completed as the event date and one or more of the following event codes on their driver record abstract:

i. PDP-M-DDCC described as POINT CREDIT—DEFENSIVE DRIVING PROG used until July 1996, for drivers with zero points;

ii. DMV-M-DDCC described as DEFENSIVE DRIVING COURSE used after July 1996, for all drivers regardless of point accumulation, in addition to the two event codes in (b)1iii and iv below that are used if the driver had a point accumulation before taking the defensive driving course;

iii. DDP-Z-PC01 described as POINT CREDIT—DEFENSIVE DRIVING PROG used for drivers with one point;

iv. DDP-Z-PC02 described as POINT CREDIT—DEFENSIVE DRIVING PROG used for drivers with two or more points; or

2. The acceptance from the insured of a certificate or other documentation from an approved defensive driving course provider that indicates that the insured successfully completed a defensive driving course.

(c) Insurers shall provide written notification of the availability of the rate reduction with all new business and renewals.

**11:3-24.6 Penalties**

Failure of an insurer to comply with these rules may result in the imposition of penalties prescribed by law.

SUBCHAPTER 25. PRIVATE PASSENGER  
AUTOMOBILE INSURANCE:  
NOTIFICATION BY TREATING HEALTH  
CARE PROVIDERS

**11:3-25.1 Purpose and scope**

(a) The purpose of this subchapter is to implement N.J.S.A. 39:6A-5, as amended by P.L. 1995, c.407, by establishing procedures to be followed by treating medical providers to give timely notification of the commencement of medical treatment for injuries sustained in automobile accidents. The subchapter sets forth:

1. Time limits for the filing of notification of the commencement of treatment for PIP claims;
2. The actions to be taken upon failure to comply with the notification time limits, including reduction or denial of claim payments;
3. The factors to be considered in evaluation of a late notification; and
4. The rights of providers when payment is reduced or denied for failure to comply with the notification requirements.

(b) This subchapter shall apply to every insurer authorized to transact the business of automobile insurance in this State. The subchapter applies to treatment for injuries resulting from automobile accidents that occur after July 8, 1996.

**11:3-25.2 Definitions**

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Coverage status” means the status of PIP coverage for an injured party pursuant to N.J.S.A. 39:6A-5.

“Department” means the Department of Banking and Insurance of the State of New Jersey.

“Eligible charge” means the treating medical provider’s usual, customary and reasonable charge or the upper limit on the medical fee schedule as found in N.J.A.C. 11:3-29.6, whichever is lower subject to provisions of N.J.A.C. 11:3-29.4.

“Emergency care” means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity (including

severe pain, psychiatric disturbance and/or symptoms of substance abuse) such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospital care, transportation to a hospital or trauma center, emergency room care, surgery, 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.

“Multiple treating medical provider” means a treating health care provider as defined herein that provides emergency care, in association with one or more other treating medical providers.

“Notification” or “notice” means a written communication, transmitted by mail, facsimile or electronic message (“E-mail”).

“Personal injury protection” or “PIP” means the coverage set forth at N.J.S.A. 39:6A-4 or 39:6A-3.1.

“PIP information” means: the name and address of the insured and the name and address of the injured party, if different; the name of the PIP insurer and the address established by the insurer for notification of commencement of medical treatment pursuant to N.J.A.C. 11:3-25.3(c); the policy number of the insurance policy providing PIP benefits; and the date of the accident/injury. A treating medical provider may obtain this information from the insured, the injured party, the hospital, a police report or any other reasonably available source.

“Secondary medical providers” means those health care providers who provide medical products, care and services to a person injured in an automobile accident only after having received a prescription from a treating health care provider. Secondary medical providers shall include, but are not limited to, pharmacists, visiting nurses, prosthetics fabricators and providers of durable medical equipment products. Notwithstanding the existence of a prescription of a treating medical provider, physical therapists, chiropractors and any secondary medical provider who seeks payment of an eligible charge in excess of \$500.00 for individual services or products provided on one occasion or in the course of 30 days shall not be considered secondary medical providers.

“Treating health care 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 which is maintained by a state or any of its political subdivisions;

2. A hospital or health care facility licensed by the Department of Health and Senior Services;

3. Other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiology and diagnostic testing, freestanding emergency clinics or offices, and private treatment centers;

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 chiropodists (podiatrists);

12. Registered bio-analytical laboratories;

13. Licensed psychologists;

14. Licensed physical therapists;

15. Certified nurse-midwives;

16. Certified nurse-practitioners/clinical nurse-specialists;

17. Licensed health maintenance organizations;

18. Licensed orthotists and prosthetists;

19. Licensed professional nurses;

20. Licensed occupational therapists;

21. Licensed speech-language pathologists;

22. Licensed audiologists;

23. Licensed physician assistants;

24. Licensed physical therapists assistants;

25. Licensed occupational therapy assistants; and

26. Providers of other health care services or supplies, including durable medical goods.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

In "Multiple treating medical provider", substituted a reference to health care providers for a reference to medical providers; in "Personal injury protection" or "PIP", inserted a reference to N.J.S.A. 39:6A-3.1; in "Secondary medical providers", substituted a reference to health care providers for a reference to medical service practitioners and providers following "those" and substituted a reference to health care providers for a reference to medical providers at the end of the first sentence; deleted "Treating medical provider"; and added "Treating health care provider".

### 11:3-25.3 Notification of commencement of treatment

(a) When medical treatment is rendered for which a claim for payment will be made pursuant to the PIP coverage of a private passenger automobile insurance policy, a treating health care provider shall provide notice to the PIP insurer no later than 21 days following the date of the commencement of such treatment.

(b) In accordance with the PIP information provided by the injured party or the insured, notice shall be sent by the treating health care provider to the insurer at the address established by the insurer for the receipt of such notice.

(c) Insurers shall establish one address where notice must be sent by treating health care providers pursuant to these rules. Insurers shall provide this address, and may provide a facsimile transmission number, and E-mail address if any, on all insurance identification cards issued by the insurer after January 6, 1997.

(d) In accordance with the provisions of N.J.A.C. 11:3-25.10, insurers shall file with the Department the address, and may provide a facsimile transmission number, and E-mail address, if any, where notice of commencement of treatment should be sent. Insurers shall also include the name and telephone number of a contact person at the insurer for this purpose. Such information shall be added to a list of insurer addresses maintained by the Department.

(e) Notice sent to the address printed on a valid insurance identification card or on the Department's current list of addresses shall be presumed to have been sent to the proper address.

(f) Within 14 days after receiving notice of the commencement of treatment, the insurer shall notify the treating health care provider of the coverage status of the person receiving treatment. If the notice from the insurer states that the coverage status of the person receiving treatment is unknown, the insurer shall make a determination of coverage and provide written confirmation to the treating health care provider no later than 60 days from receipt of notice of commencement of treatment. Examples where the coverage status may not be known are when the injured person is not a named insured, principal or occasional operator, or is not otherwise listed as a resident of the insured household on the most recent information provided to the insurer by the named insured.

(g) The notice requirements set forth in (a) through (c) above and the eligible charge reductions contained in N.J.A.C. 11:3-25.5 shall not apply to secondary medical providers, except as noted in the definition of that term found in N.J.A.C. 11:3-25.2.

(h) In calculating the time for notice in (a) and (f) above, the day treatment begins or the day the insurer receives notice from the treating health care provider is not to be included. If the last day for providing notice falls on a Saturday, Sunday or legal holiday, the time runs to the next business day.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Substituted references to health care providers for references to medical providers throughout.

#### 11:3-25.4 Content of notice and proof of receipt

(a) The treating health care provider shall send the written notice required by N.J.A.C. 11:3-25.3(a) to the PIP insurer on either:

1. The "Notification of Commencement of Medical Treatment Form" found in Appendix A, appended to and incorporated by reference in this subchapter; or
2. A bill or invoice rendered by the treating health care provider that includes at a minimum the information required in the "Notification of Commencement of Medical Treatment Form" in Appendix A.

(b) When any notice required by this subchapter is mailed, the postmark shall be the proof of mailing. The insurer shall retain evidence of untimely mailing of the notice whenever it denies or reduces payment pursuant to N.J.A.C. 11:3-25.5.

(c) In those cases where facsimile or E-mail notice is authorized by the insurer when any notice required by this subchapter is sent by facsimile or by E-mail, the proof of notice shall be the facsimile transmission receipt generated by the sender's facsimile machine, a copy of the E-mail message showing the date and time of transmittal or an acknowledgment of receipt generated by the receiving system. Nothing in this section shall prohibit treating health care providers and insurers from mutually agreeing to accept other proofs of notice for electronic transmissions. It shall be the responsibility of the treating health care provider to retain proof of notice of commencement of treatment transmitted by facsimile or other electronic means.

(d) Any notice given pursuant to this subchapter shall be deemed to have been made on the date of postmark or the date of transmission in the case of facsimile transmission and E-mail.

(e) When a bill or invoice is used to provide notice of the commencement of treatment in accordance with this subchapter, it shall not be deemed to constitute notice unless

the following message appears on the first page of the bill or invoice: "21 DAY NOTICE" or "FIRST BILL 21 DAY NOTICE." This message shall be in contrasting color ink and be in at least 12 point capital letters. Use of a rubber stamp or affixed label is acceptable for purposes of complying with this subsection.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

In (a) and (c), substituted references to health care providers for references to medical providers; and added (e).

#### 11:3-25.5 Late notification

(a) In the event notice of commencement of medical treatment is made after 21 days, the insurer shall advise the treating health care provider in writing of the late notification and may reserve the right to reduce payment in accordance with (b) below.

(b) Where notice of the commencement of medical treatment is not timely provided in accordance with this subchapter, an insurer may apply the following reductions to the eligible charges:

1. 22 to 30 days after the commencement of treatment: 10 percent reduction.
2. 31 to 60 days after the commencement of treatment: 25 percent reduction.
3. 61 to 120 days after the commencement of treatment: 50 percent reduction.
4. 121 to 160 days after the commencement of treatment: 75 percent reduction.
5. 161 or more days from the commencement of treatment: 100 percent reduction.

(c) If notice is not provided as required by this subchapter, the reduction formula set forth in (b) above shall apply to all eligible charges for which the treating health care provider seeks payment through such late notice.

(d) Insurers shall not reduce an eligible charge under the following circumstances:

1. When the provider is a member of the group of multiple treating health care providers giving emergency care during the initial hospitalization as defined in N.J.A.C. 11:3-25.2;
2. When the provider is a secondary medical provider as defined in N.J.A.C. 11:3-25.2; or
3. When the medical condition of the injured party made it impossible to comply with the notice requirement.

New Rule, R.1997 d.14, effective January 6, 1997 (operative March 7, 1997).

See: 28 N.J.R. 3876(a), 29 N.J.R. 132(a).

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Substituted references to health care providers for references to medical providers throughout.

### 11:3-25.6 Standards for adjustment of reduction

(a) Notwithstanding the reductions set forth in N.J.A.C. 11:3-25.5(b), insurers may choose to pay the full or a less reduced amount of an eligible charge based upon consideration of the following factors:

1. Whether the treating health care provider has previously provided untimely notice under this subchapter or has established a pattern of untimely notice;
2. The cost of medical treatment provided by the treating health care provider between the time treatment commenced, when notice was due and when it was provided;
3. The injured party was a pedestrian who did not have PIP coverage as the named insured or resident relative under another policy and the circumstances are such that additional time is necessary to identify the policy under which coverage is being provided;
4. Any potential adverse impact on the public; and
5. Such other factors as the insurer may determine.

(b) Within 60 days of receipt of notice, or such additional time as may be afforded under N.J.S.A. 39:6A-5g, the insurer shall give the treating health care provider notice of its final determination as to payment, reduction or denial of payment of an eligible charge. Such notice shall be clearly labeled "Final Determination," and it shall refer clearly to the injured party, the insured, the claim number, the date of accident, the date of first treatment, the date notice of the commencement of treatment was made and the acceptance or rejection of any of the standards of adjustment of the reduction in (a) above and N.J.A.C. 11:3-25.5(b).

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Substituted references to health care providers for references to medical providers throughout.

### 11:3-25.7 Responsibility for payment

Whenever an eligible charge has been reduced or denied pursuant to N.J.A.C. 11:3-25.5(b), the treating health care provider shall not seek to obtain payment directly from the insured or the person receiving treatment.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Substituted a reference to health care providers for a reference to medical providers.

### 11:3-25.8 Procedure for appeals

A treating health care provider who fails to notify the insurer within 21 days and whose claim has been reduced or denied by the insurer pursuant to N.J.A.C. 11:3-25.5(b) may, in the discretion of a judge of 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 the receipt of the insurer's final determination of reduction or denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to notify the insurer within 21 days of the commencement of treatment.

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

Substituted a reference to health care providers for a reference to medical providers in the first sentence.

### 11:3-25.9 Reporting requirement

(a) By February 5, 1997, every insurer shall file with the Department the address, facsimile number (if notice by facsimile is permitted) and E-mail address, if any, of the designated location for the filing of notice required under this subchapter. Insurers shall use Appendix B, appended to and incorporated by reference in this subchapter, to report the information required by this subsection.

(b) Insurers shall complete and file the information in Appendix B by January 1 of each year.

(c) Completed copies of Appendix B shall be submitted to:

Department of Banking and Insurance  
Director of Public Affairs  
PO Box 325  
Trenton, New Jersey 08625-0325

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).

See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).

### 11:3-25.10 Compliance

For treatments rendered between January 6, 1997 and July 6, 1997, all eligible charge reductions set forth in N.J.A.C. 11:3-25.5(b) shall be reduced by 50 percent (for example, a 10 percent reduction shall be five percent, a 25 percent reduction shall be 12.5 percent, etc.).

## APPENDIX A

Notification of Commencement of Medical Treatment  
(to be filed with insurer)

Name, address and phone number of Treating Health Care Provider:

---

\_\_\_\_\_

Fax Number (optional) \_\_\_\_\_

\_\_\_\_\_

Name and address of patient: \_\_\_\_\_ Name and address of insured:  
(if different) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insurer Name: \_\_\_\_\_

Insurer Address: \_\_\_\_\_

\_\_\_\_\_

Policy No. \_\_\_\_\_

Date of accident/injury: \_\_\_\_\_

Date of first treatment: \_\_\_\_\_

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).  
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).  
Substituted a reference to Treating Health Care Providers for a reference to Treating Medical Providers

**APPENDIX B**

**Address for Notification of Commencement  
of Medical Treatment**

Insurance Co. Name: \_\_\_\_\_

NAIC Group #: \_\_\_\_\_ NAIC Company #: \_\_\_\_\_

Address established by insurer for the filing of the notification of the commencement of PIP treatment by Treating Health Care Providers

Address: \_\_\_\_\_

\_\_\_\_\_

Facsimile Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

To be filed with:

Department of Banking and Insurance  
Division of Public Affairs  
PO Box 325  
Trenton, NJ 08625-0325  
Attn: Notification of Treatment List

Amended by R.1998 d.591, effective December 21, 1998 (operative March 22, 1999).  
See: 30 N.J.R. 3202(a), 30 N.J.R. 4390(b).  
Substituted a reference to Treating Health Care Providers for a reference to Treating Medical Providers.

**SUBCHAPTER 26. UNSATISFIED CLAIM AND  
JUDGMENT FUND: NOTICE OF INTENT**

**11:3-26.1 Claim information**

(a) Notice of intention to make a claim under N.J.S.A. 39:6-65 shall contain the following information:

1. The claimant's name, address, date of birth and social security number;
2. The time, date, location, municipality and county in which the loss occurred;
3. The identity of the operators and vehicles involved in the accident, including the name and address of the owner and operator and the license plate number of the vehicle;
4. Such witnesses to said accident as are then known;
5. A short description of the accident, including the claimant's role or position therein;
6. A description of the injuries then known, and attached thereto a medical certificate if then available. In any event the medical certificate shall be filed as soon as available;
7. A description of the damage sustained to property, and attached thereto an estimate of the cost of repairs if then available; and
8. The policy number of any insurance applicable to the accident, including the name and address of all insurance companies involved.

Amended by R.1991 d.45, effective February 4, 1991.  
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).  
In (a)1-5: added text to contents of claim information notice. Added new (a)8.  
Amended by R.1996 d.58, effective February 5, 1996.  
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

**11:3-26.2 Claim filing; form**

(a) A Notice of Intention to make Claim under N.J.S.A. 39:6-65 may be filed on form UCJF #72 of the Unsatisfied Claim and Judgment Fund Board designated as a "Notice of Intention to Make Claim", incorporated herein by reference as Appendix A.

(b) A written notice to the Board in any other form that contains the information required by this section shall be acceptable.

(c) A notice of intention to make a claim that does not contain the items identified in N.J.A.C. 11:3-26.1(a) 1 through 8 shall be returned to the sender and deemed to be not filed with the Unsatisfied Claim and Judgment Fund (UCJF) for the purpose of complying with N.J.S.A. 39:6-65 and shall not toll the statute of limitations.

Amended by R.1991 d.45, effective February 4, 1991.  
See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).  
Added new subsection (c).  
Amended by R.1996 d.58, effective February 5, 1996.  
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).  
Amended by R.1997 d.85, effective February 18, 1997.  
See: 28 N.J.R. 5030(a), 29 N.J.R. 551(a).  
In (a), inserted form number and reference to Appendix A.

APPENDIX A

NEW JERSEY DEPARTMENT OF INSURANCE

UCJ-

TO: UNSATISFIED CLAIM AND JUDGMENT FUND CN 326 TRENTON NJ 08625-0326

NOTICE OF INTENTION TO MAKE CLAIM

NOTICE OF INTENTION TO MAKE CLAIM FOR PAYMENT FROM THE FUND MUST BE MADE WITHIN NINETY (90) DAYS OF THE DATE OF THE ACCIDENT; OTHERWISE, THE RIGHT TO COLLECT FROM THE FUND WILL BE LOST. N.J.S.A. 39:6-65

READ SECTION 7 BEFORE COMPLETING THIS FORM. ANSWER ALL QUESTIONS. INCOMPLETE FORMS MAY BE RETURNED. N.J.A.C. 11:3-26.2

1-CLAIMANT

CLAIMANT NAME LAST FIRST MI SOC. SEC. # DATE OF BIRTH

ADDRESS COUNTY

MUNICIPALITY STATE ZIP CODE

Were you injured? Yes No If yes, describe injuries

If you were injured, a medical certificate must accompany this notice, or must be filed as soon as possible. N.J.A.C. 11:3-26.1(a)(6) Did you sustain property damage other than to your vehicle? Yes No If yes, submit cost of repairs if available. \$ N.J.A.C. 11:3-26.1(a)(7)

2-THE ACCIDENT

DATE OF ACCIDENT TIME OF ACCIDENT A.M. P.M. CHECK ONE

LOCATION OF ACCIDENT-STREET/HIGHWAY

MUNICIPALITY STATE COUNTY

DESCRIBE ACCIDENT

WERE YOU A: PEDESTRIAN (OR) PASSENGER IN VEHICLE NO. DRIVER (See below for vehicle number)

Vehicle No. 1-License Plate No. Owned by: Address: Driven by: Address: Driver's License No. Insured by: Policy No. Agent

Vehicle No. 2-License Plate No. Owned by: Address: Driven by: Address: Driver's License No. Insured by: Policy No. Agent

3-WITNESSES TO THE ACCIDENT

(FIRST NAME) (LAST NAME) Address (STREET) (CITY) (STATE)

(FIRST NAME) (LAST NAME) Address (STREET) (CITY) (STATE)

IMPORTANT-QUESTIONS ON REVERSE SIDE MUST BE ANSWERED AND FORM SIGNED.

UCJF #72