"Health care provider" or "provider" means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to:

1. A hospital or health care facility 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.

"Health care service" means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of diagnosis or treatment of pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board.

"Insurer" means any person authorized or admitted in this State to write the kinds of insurance specified in paragraphs d and e of N.J.S.A. 17:17-1, pursuant to N.J.S.A. 17:17-1 et seq. or 17:32-1 et seq., as applicable. "Insurer" shall not include a surplus lines insurer eligible to write business pursuant to N.J.S.A. 17:22-6.40 et seq.

"Licensed nursing personnel" or "licensed nurse" means a nurse licensed by the New Jersey State Board of Nursing or the equivalent from another jurisdiction.

"Medical expense benefits" means medical expense benefits paid in accordance with N.J.S.A. 39:6A-4a or 39:6A-3.1 and N.J.A.C. 11:3-4.

"Medically necessary" is as defined in N.J.A.C. 11:3-4.2.

"Per diem" means a daily fixed charge which includes room and board and other fees for services and supplies.

"PIP coverage" means personal injury protection coverage as described in N.J.S.A. 39:6A-4 or 39:6A-3.1.

"Person" means any individual, association, company, corporation, insurer, joint stock company, organization, partnership, society, syndicate, trust, any combination of the foregoing acting in concert or any other entity.

"Pre-screen" means an off-site review of the billings from a health care facility to determine whether the care given and amounts charged are appropriate.

"Provider" means any person that furnishes services or equipment for medical expense benefits for which payment is required to be made under PIP coverage in automobile insurance policies, but does not include health care facilities.

"Reimbursement" refers to reimbursement to insurers by the Fund as provided at N.J.S.A. 39:6-73.1.

"Uninsured motorist claims" means claims submitted against operators of uninsured vehicles and hit and run claims submitted pursuant to N.J.S.A. 39:6-61.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).
Amended by R.1994 d.597, effective December 5, 1994.
See: 26 N.J.R. 2190(a), 26 N.J.R. 4772(a).

Amended by R.1997 d.535, effective December 15, 1997.
See: 29 N.J.R. 4246(a), 29 N.J.R. 5309(a).
Amended "Insurer".
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 "Excess medical expenses benefits", inserted a reference to N.J.S.A. 39:6A-4.3 and 39:6A-3.1; in "Health care facility", inserted "health care provider that is a" following "means a"; inserted "Health care provider" or "provider"; in "Medical expense benefits", added a reference to N.J.S.A. 39:6A-3.1 and N.J.A.C. 11:3-4; rewrote "Medically necessary"; in "PIP coverage", added a reference to N.J.S.A. 39:6A-3.1; and deleted "Provider".
Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).
Rewrote definition "Board".

11:3-28.3 Report of claims when the carrier has paid at least $50,000 for medical expense benefits

In cases where the potential exposure to the automobile liability insurer exceeds $75,000, the insurer shall report on UCJF Form 1(321) (incorporated herein by reference as Form 1 in Appendix A) whenever medical expense benefits in a total amount of $50,000 have been paid on account of personal injury to any one person in any one accident.

Recodified from 11:3-28.2 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).
Amended by R.1997 d.85, effective February 18, 1997.
See: 28 N.J.R. 5030(a), 29 N.J.R. 551(a).
Amended form references.

11:3-28.4 Notice of change in the amount of reserves

Whenever an automobile liability insurer has paid medical expense benefits on account of personal injury to any one person in any one accident in a total amount of $50,000, said insurer shall notify the Fund of any changes in the amount of reserves established for payment of the claim or closing of the file.

Recodified from 11:3-28.3 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.5 Supplemental forms to be submitted to the Fund

(a) UCJF Form 2(RR) (incorporated herein by reference as Form 2 in Appendix A), shall be filed with the Fund within 90 days after an automobile insurer has paid medical expense benefits on account of personal injury to any one person in any one accident in a total amount in excess of $75,000. Such form together with UCJF Form 3(323) (incorporated herein by reference as Form 3 in Appendix A) shall be filed each quarter thereafter that the insurer seeks reimbursement.

(b) Any office of an insurer seeking reimbursement of funds from the UCJF for personal injury protection medical expense must also complete and file with the UCJF a New Jersey Information Questionnaire, UCJF Form 4(W-9) (incorporated herein by reference as Form 4 in Appendix A).

Recodified from 11:3-28.4 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(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), amended form references; and added (b).

11:3-28.6 Insurer's continuing obligation to investigate claims

(a) An automobile liability insurer shall be required to discharge its duty of investigating claims where the potential exposure to the insurer exceeds $75,000. Said insurer's duty and obligation with regard to claim handling shall exist and continue to exist notwithstanding this rule. The Executive Director may direct such investigations as often as he or she deems necessary. All expenses relating to the investigation of claims, including expenses for medical examinations, file maintenance and cost containment measures, are the responsibility of the automobile liability insurer.

(b) The failure to properly discharge the duty of investigating a claim may result in the imposition of a penalty, to be determined by the Board's designee against the insurer's request for reimbursement.

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 (b) to text, therein creating subsection (a) to existing text.
Recodified from 11:3-28.5 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).
Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).
Substituted "Board's designee" for "UCJF Board of Directors" in (b).

Case Notes

Insurer may request claimant to undergo physical or mental examination after cessation of benefits. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D.1992).

Insurer may seek examination under oath of claimant after termination of benefits or demand of arbitration. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D.1992).

Insurer's denial of benefits to claimant who refused examination under oath was not warranted. New Jersey Auto. Full Ins. Underwriting Ass'n v. Jallah, 256 N.J.Super. 134, 606 A.2d 839 (A.D.1992).

11:3-28.7 Reimbursement of excess medical expense benefits paid by insurers

(a) Insurers shall submit to the Fund itemized accounts with supporting documentation of excess medical expense benefit claim payments as soon as practicable after the close of the quarter for which reimbursement is sought for claim payments of $20,000 or more. For claim payments of less than $20,000, insurers shall submit to the Fund itemized accounts with supporting documentation of excess medical expense benefits either quarterly or at the close of the calendar year in which such expenses are incurred. Insurers

shall not be reimbursed for interest, attorney fees or punitive damages.

1. For a period of one year from the date of payment of a claim for excess medical expense benefits by an insurer, the insurer may submit to the Fund a request for reimbursement of a claim which was not included in the insurer's quarterly submission. The insurer shall include with its request, specific documentation to identify the subject payment.

2. Failure to comply with the requirements set forth in (a)1 above shall result in a denial by the Fund of the reimbursement request which was omitted from the quarterly submission.

(b) The Fund shall not reimburse an insurer for excess medical expense benefits if it is determined that there are multiple insurance policies applicable to a claim unless an insurer has expended medical benefits in an amount exceeding $75,000 on account of personal injury to any one person in any one accident. Where there are two or more different primary insurers liable, the Fund shall not reimburse such an insurer for excess medical expense benefits unless each primary insurer has expended medical benefits in an amount exceeding $75,000 on account of personal injury to any one person in any one accident.

(c) Where the Fund has reimbursed an insurer for excess medical expense benefits and thereafter determines that there were or are multiple insurance policies applicable to the underlying claim, the insurer shall return all moneys paid from the Fund. The insurer(s) shall apportion the medical benefits payment and make individual application to the Fund where the potential exposure to the insurer(s) exceeds $75,000 on account of personal injury to any one person in any one accident.

(d) Whenever an insurer recovers amounts expended by it for medical benefits, it shall not be reimbursed for excess medical expense benefits unless it has fully repaid the amount previously reimbursed by the Fund.

Recodified from 11:3-28.6 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).
Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).
Rewrote (a).

Case Notes

Unsatisfied Claim and Judgment Fund not required to reimburse insurers of out-of-state vehicles for PIP benefits in excess of $75,000. Martin v. Home Ins. Co., 141 N.J. 279, 661 A.2d 808 (1995).

11:3-28.8 Audits

Upon request of the Fund, the insurer(s) shall present for audit at the direction of the Executive Director at a New Jersey location all policy and claim records on which notice of potential for payment of excess medical expense benefits have been submitted.

Recodified from 11:3-28.7 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.9 Reporting of losses for personal injury protection payments in excess of $75,000

(a) For purposes of completing page 14, Exhibit of Premiums and Losses, of the annual statement filed pursuant to N.J.S.A. 17:23-1, the insurer shall include the total amount of losses for private passenger automobile and commercial automobile personal injury protection payments (lines 19.1 and 19.3), including those in excess of $75,000. Insurers shall also provide a footnote on page 14 that indicates the amount of losses reported, excluding losses from payments of private passenger automobile and commercial automobile personal injury protection payments in excess of $75,000.

(b) For purposes of completing Schedule F of the annual statement, insurers shall consider the assumption and reimbursement by the Fund of private passenger automobile and commercial automobile personal injury protection payments in excess of $75,000 as a reinsurance transaction. Insurers shall consider assessments paid to the UCJF pursuant to N.J.S.A. 39:6-63 based on the insurer's premiums for private passenger automobile liability insurance (including PIP) and commercial automobile liability insurance (including PIP) as ceded premium, pro rated for the appropriate line of business on which the assessment was based.

(c) Insurers shall comply with the provisions of this section beginning with the annual statement due March 1, 1994 (covering the calendar year ended December 31, 1993). For purposes of completing the annual statement due March 1, 1993 (covering the calendar year ended December 31, 1992), insurers shall file by no later than July 1, 1993 a supplemental page 14 and schedule F of the annual statement in accordance with the provisions of this section.

New Rule, R.1993 d.178, effective April 19, 1993.
See: 24 N.J.R. 3215(a), 24 N.J.R. 1769(a).
Recodified from 11:3-28.8 and amended by R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(a).

11:3-28.10 Insurers' obligations to investigate and audit bills for medical benefits

(a) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by health care facilities where such claims are equal to or in excess of $25,000 and an on-site audit where such claims are equal to or in excess of $50,000.

1. Failure of an insurer to complete an audit in accordance with these rules shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

2. Per diem billings for health care facilities are not subject to the audit requirements set forth in this subchapter.

3. An insurer shall conduct any such audit to determine whether the level of care, need and charges are appropriate.

4. An insurer may pay 80 percent of the provider's bill prior to completion of the initial on-site audit. The remaining amount due, if any, shall be paid following completion of the insurer's audit.

5. Annual on-site audits shall be completed in 12-month intervals, from the initial on-site audit and shall be filed with the Fund within 90 days of completion of the audit; and

6. Whenever a change in services occurs such as, but not limited to, the level of care, the daily room rate or additional charges, an insurer shall conduct an on-site audit and shall provide the audit and auditor's statement to the Fund with the next reimbursement request.

7. All other audits shall be conducted prior to payment to the health care facility and may be performed on a pre-screen basis as set forth in (e) below.

(b) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by providers other than health care facilities where such claims are equal to or in excess of $10,000.

1. Failure of an insurer to complete an audit in accordance with this subchapter shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

(c) The thresholds in (a) and (b) above are cumulative for each confinement associated with damages resulting from bodily injuries arising out of the ownership, maintenance or use of a motor vehicle in this State and shall incorporate all claims submitted per confinement by the provider.

(d) To be eligible for reimbursement by the Fund, insurers shall audit, prior to payment, bills submitted for continuous treatment from any provider which exceed or may exceed the applicable threshold.

(e) Audits of all providers conducted pursuant to this subchapter, including the audit of DRG bills and successor pricing, shall be performed by:

1. Licensed nursing personnel with two years experience or training in required auditing and hospital practices; or

2. An outside auditing firm retained by the insurer for such purposes.

(f) Audits performed shall include, but not be limited to, confirmation of compliance with the medical fee schedule set forth at N.J.A.C. 11:3-29 including those situations where the insurer does not provide the primary coverage to the claimant.

(g) An insurer is not required to conduct a separate, independent audit, if it has obtained a true copy of an audit conducted by the primary insurer or health insurer.

(h) Insurers shall append copies of audits conducted, including those conducted by the primary insurer or health insurer, and the auditor's statements with the reimbursement request filed with the Fund in accordance with N.J.A.C. 11:3-28.7.

New Rule, R.1993 d.583, effective November 15, 1993.
See: 25 N.J.R. 2636(b), 25 N.J.R. 5219(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).
In (b), inserted "other than health care facilities" following "providers" in the introductory paragraph; in (c), deleted "health care facility or by each individual" preceding "provider"; and in (d) and (e), deleted references to health care facilities.
Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).
In (a), added "and an on-site audit where such claims are equal to or in excess of $50,000"; in (a)3, substituted "any such audit" for "an initial on-site audit for changes by health care facilities".

11:3-28.11 Modifications to vehicles

(a) An insurer shall obtain prior approval from the Fund for modifications to a claimant's vehicle, or vehicle to be used for the benefit of the claimant, the cost of which may be reimbursed by the Fund.

(b) An insurer shall submit a written request to the Fund, including a Van Purchase and Modification Agreement seeking approval of modifications which are equal to or in excess of $1,000, within 30 days of a claimant's request for modifications.

(c) A request to obtain prior approval from the Fund shall include the following:

1. A written recommendation for the modification by the claimant's primary care physician including:

i. Where the claimant is the operator of the vehicle, current findings on the claimant's physical ability to drive and a copy of the claimant's current driver's license;

ii. A brief analysis of the medical necessity and medical purpose for the requested modifications;

iii. A description of the purpose for which the vehicle will be used; and

iv. Verification that the requested modifications are necessitated by injuries sustained by the claimant in the subject accident;

2. A cost benefit analysis, supported by appropriate documentation, comparing the cost of modifying the claimant's vehicle to the cost of alternate methods of transporting the claimant. This analysis shall incorporate an evaluation of the anticipated miles to be driven per year for medically necessary health care services, including a