

1. Every insurer shall establish a single address where requests for dispute resolution shall be sent. Insurers shall notify the administrator of the address and any changes thereto. The administrator shall make the list of insurer addresses available to the user community on a web page and any other available means of communication.

2. Providers who are the assignee of benefits by the insured or have a power of attorney from the insured shall follow the insurer's internal appeal process mandated by N.J.A.C. 11:3-4.7B before making a request for dispute resolution in accordance with (a) above. The dispute resolution organization's plan shall include a procedure for how the provider shall demonstrate that this requirement has been satisfied.

(b) Upon receipt of the request, the administrator shall promptly assign the matter to a dispute resolution professional. For in-person proceedings, the administrator shall notify all parties of the DRP assigned at the time the assignment is made. For on-the-papers proceedings, the parties will receive notice of the DRP assigned at the time the decision is issued.

(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 pre-existing 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.

(e) Pursuant to N.J.S.A. 39:6A-5.2(g), the costs of the proceedings shall be apportioned by the DRP and the award may include reasonable attorney's fees for a successful claimant in an amount consonant with the award. Where attorney's fees for a successful claimant are requested, the DRP shall make the following analysis consistent with the jurisprudence of this State to determine reasonable attorney's fees, and shall address each item below in the award:

1. Calculate the "lodestar," which is the number of hours reasonably expended by the successful claimant's

counsel in the arbitration multiplied by a reasonable hourly rate in accordance with the standards in Rule 1.5 of the Supreme Court's Rules of Professional Conduct (http://www.judiciary.state.nj.us/rules/appendices/rpc.htm#P65_6482).

i. The "lodestar" calculation shall exclude hours not reasonably expended;

ii. If the DRP determines that the hours expended exceed those that competent counsel reasonably would have expended to achieve a comparable result, in the context of the damages prospectively recoverable, the interests vindicated, and the underlying statutory objectives, then the DRP shall reduce the hours expended in the "lodestar" calculation accordingly; and

iii. The "lodestar" total calculation may also be reduced if the claimant has only achieved partial or limited success and the DRP determines that the "lodestar" total calculation is therefore an excessive amount. If the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.

2. DRPs, in cases when the amount actually recovered is less than the attorney's fee request, shall also analyze whether the attorney's fees are consonant with the amount of the award. This analysis will focus on whether the amount of the attorney's fee request is compatible and/or consistent with the amount of the arbitration award. Additionally, where a request for attorney's fees is grossly disproportionate to the amount of the award, the DRP's review must make a heightened review of the "lodestar" calculation described in (e)1 above.

(f) 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 ordered in the award pursuant to N.J.S.A. 39:6A-5, within 45 days of the insurer's receipt of a copy of the determination, unless one of the actions permitted in (g) below has been filed. Where the arbitration has been filed by a provider who is the assignee of benefits pursuant to N.J.A.C. 11:3-4.7B, the payment shall be made payable to the provider.

(g) The final determination of the dispute resolution professional shall be binding upon the parties, but subject to clarification/modification and/or appeal as provided by the rules of the dispute resolution organization, and/or 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".
Amended by R.2004 d.218, effective June 7, 2004.

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a).

In (a), added 1.

Amended by R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).

See: 43 N.J.R. 1640(a), 44 N.J.R. 383(a), 44 N.J.R. 2652(c).

In the introductory paragraph of (a), inserted "pursuant to N.J.A.C. 11:3-4.9"; added (a)2 and new (e); rewrote (b); recodified former (e) and (f) as (f) and (g); and rewrote (f) and (g).

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.

11:3-5.8 Medical review organizations

(a) Medical review organizations shall be authorized to determine in connection with the PIP dispute resolution process set forth in this subchapter:

1. Whether the medical treatment or diagnostic test is medically necessary;

2. Whether the treatment is in accordance with medically recognized standard protocols including those protocols approved by the Commissioner and set forth in N.J.A.C. 11:3-4;

3. Whether the treatment is consistent with symptoms or diagnosis of the injury;

4. Whether the injury is causally related to the accident;

5. Whether the treatment is of a palliative rather than a restorative nature; and

6. Whether medical procedures and tests that have been repeated are medically necessary.