

Recodified from 11:3-2B.5 and amended by R.1995 d.50, effective January 17, 1995.

See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

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

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

11:3-2B.8 Confidentiality of documents

The information provided by a claimant pursuant to N.J.A.C. 11:3-2B.6 or 2B.7 as part of an application for a hardship exemption or appeal from a decision of the MTF shall be confidential and not subject to public inspection or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq.

Recodified from 11:3-2B.6 and amended by R.1995 d.50, effective January 17, 1995.

See: 26 N.J.R. 4590(a), 27 N.J.R. 368(a).

SUBCHAPTER 3. BASIC AUTOMOBILE INSURANCE POLICY

Authority

N.J.S.A. 17:1-8.1 and 17:1-15e and P.L. 1998, c.21.

Source and Effective Date

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).

11:3-3.1 Purpose and scope

(a) This subchapter provides rules to be utilized by insurers in developing the policy forms and rates for basic automobile insurance policies to be filed with and approved by the Department in accordance with the provisions of N.J.S.A. 39:6A-3.1.

(b) This subchapter shall apply to all insurers writing private passenger automobile insurance on personal lines policy forms, including the New Jersey Personal Automobile Insurance Plan established by N.J.A.C. 11:3-2.

11:3-3.2 Definitions

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

"Basic automobile insurance policy" or "basic policy" means that automobile insurance policy offered pursuant to N.J.S.A. 39:6A-3.1 and this subchapter.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

"Insurer" means any person or persons, corporation, association, partnership, company, reciprocal exchange, or other legal entity authorized or admitted to transact private passenger automobile insurance in this State, or any one member of a group of affiliated companies that transacts business in accordance with a common rating system.

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

"Personal injury protection" or "PIP" means the benefits and coverages set forth at N.J.S.A. 39:6A-4 and 39:6A-3.1 and N.J.A.C. 11:3-4.

"Standard automobile insurance policy" or "standard policy" means that policy form filed by private passenger automobile insurers and approved by the Commissioner that contains the coverages and options pursuant to N.J.S.A. 39:6A-4.

11:3-3.3 General provisions

(a) All insurers writing private passenger automobile insurance and the Personal Automobile Insurance Plan shall file for approval with the Department their rates, rules and policy forms for a basic automobile insurance policy to be issued in accordance with N.J.S.A. 39:6A-3.1 and this subchapter.

(b) An insurer shall make available the basic policy at either a single tier rate or at multiple tier rates, consistent with its tier rating system filed and approved pursuant to N.J.A.C. 11:3-19A. If more than one basic policy rate is offered, each shall be identified as part of a standard, non-standard or preferred tier.

(c) If a named insured has elected basic automobile insurance coverage and other immediate family members or resident relatives of the named insured have higher policy limits under a standard policy, the provisions of N.J.S.A. 39:6A-4.2 shall apply and the named insured shall only be entitled to the coverages provided under his or her basic policy.

(d) Basic policies shall provide the tort option provided under N.J.S.A. 39:6A-8a.

(e) Initial rates by coverage for basic policies filed in accordance with this subchapter shall demonstrate consistency with the rates in the insurer's standard policy, adjusted for reduced coverage limits.

(f) Insurers shall file for approval an initial basic policy rating system by January 20, 1999.

11:3-3.4 Coverages; mandatory and optional

(a) The following coverages shall be included in all basic policies:

1. Personal injury protection medical expense benefits coverage in an amount not to exceed \$15,000 per person,

per accident; except that all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requiring critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician shall be covered in an amount not to exceed \$250,000, including the \$15,000 above. The medical expense benefits provided herein shall be in accordance with N.J.A.C. 11:3-4; and

2. Liability insurance coverage insuring against loss resulting from liability imposed by law for property damage sustained by any person arising out of the ownership, maintenance, operation or use of an automobile in an amount or limit of \$5,000, exclusive of interest and costs, for damage to property in any one accident.

(b) Insurers shall also make available in the basic policy, at the option of the insured, liability insurance coverage for bodily injury or death in an amount or limit of \$10,000, exclusive of interest and costs, on account of the injury or death of one or more persons in any one accident.

(c) Insurers may make available with the basic policy, at the option of the insured, comprehensive and collision coverage with deductibles filed and approved pursuant to N.J.A.C. 11:3-13.

(d) Basic policies shall not contain any other coverages, options, limits or deductibles other than those which are set forth in (a) through (c) above. Increased policy limits, the health insurance primary option for automobile medical expense coverage and uninsured/under-insured motorist coverages shall not be provided in basic policies.

11:3-3.5 Election of basic automobile insurance policy coverage and reporting

(a) No insurer shall issue a basic automobile insurance policy unless the named insured has signed a written document entitled "basic automobile insurance policy coverage selection form" set forth in N.J.A.C. 11:3-15.7.

(b) For the years 1999 through 2003, each insurer writing basic automobile insurance policies shall report the number of basic automobile insurance in-force exposures as of December 31 together with the age of the named insured and the territories in which the named insured resides on a form prescribed by the Commissioner, and filed no later than the next occurring February 15.

11:3-3.6 Filing requirements

(a) Insurers initially filing basic policy rating systems shall include the following:

1. A complete set of policy forms and endorsements that provide the mandatory and optional coverages as set forth in this subchapter;
2. Rates and rules as necessary;
3. An actuarial memorandum that supports the rate differentials from the insurer's standard policy rates;
4. The declaration page;
5. The rating information form; and
6. The personal lines filing forms as set forth in N.J.A.C. 11:3-16.3(f) and (g).

(b) Subsequent amendments to the rating systems shall be filed pursuant to N.J.A.C. 11:3-16 and other applicable statutes and rules.

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 39:6A-3.1a and 39:6A-4a.

Source and Effective Date

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).

11:3-4.1 Scope and purpose

(a) This subchapter implements the provisions of N.J.S.A. 39:6A-3.1, 39:6A-4 and 39:6A-4.3 by identifying the personal injury protection medical expense benefits for which reimbursement of eligible charges will be made by automobile insurers under basic and standard policies and by motor bus insurers under medical expense benefits coverage.

(b) This subchapter applies to all insurers that issue policies of automobile insurance containing PIP coverage and policies of motor bus insurance containing medical expense benefits coverage.

(c) This subchapter shall apply to those policies that are issued or renewed on or after March 22, 1999.

11:3-4.2 Definitions

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

"Basic automobile insurance policy" or "basic policy" means those private passenger automobile insurance policies issued in accordance with N.J.S.A. 39:6A-3.1 and N.J.A.C. 11:3-3.

“Control” or “controlled” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person, provided that no such presumption of control shall of itself relieve any person so presumed to have control from any requirement of P.L. 1970, c.22 (N.J.S.A. 17:27A-1 et seq.). This presumption may be rebutted by a showing made in the manner provided by N.J.S.A. 17:27A-3j that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and an opportunity to be heard, and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

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

“Dispute resolution organization” or “DRO” means an organization that meets the standards set forth in N.J.S.A. 39:6A-5.1 and N.J.A.C. 11:3-5.4.

“Dispute resolution professional” or “DRP” means a natural person who meets the standards set forth in N.J.A.C. 11:3-5.5

“Medical review organization” or “MRO” means an organization of health care professionals who are licensed in New Jersey, which is certified by the Commissioner to engage in unbiased medical review of the medical care provided to persons injured in automobile accidents in accordance with N.J.S.A. 39:6A-5.2 and this subchapter. The term includes either ;

1. Any peer review organization with which the Federal Health Care Financing Administration or the State contracts for medical review of Medicare or medical assistance services; or
2. Any independent health care review company.

“Personal Automobile Insurance Plan” or “PAIP” means the personal lines automobile insurance residual market mechanism established pursuant to N.J.S.A. 17:29D-1 by N.J.A.C. 11:3-2.

“Personal injury protection” or “PIP” means the coverage provided by a policy of automobile insurance pursuant to N.J.S.A. 39:6A-3.1 or 39:6A-4.

“PIP dispute” includes, but is not limited to, matters concerning:

1. Interpretation of the insurance contract’s PIP provisions;
2. Whether the medical treatment or diagnostic tests are in accordance with the provisions of applicable statutes and rules for the basic and standard policies and in compliance with the terms of the policy;
3. Eligibility of the treatment or service for compensation or reimbursement, including whether the injury is causally related to the accident and the application of deductible and copayment provisions;
4. Eligibility of the provider performing the service to be compensated or reimbursed under the terms of the policy and the provisions of N.J.A.C. 11:3-4, and including whether the provider is licensed or certified to perform the treatment or service;
5. Whether the treatment was actually performed;
6. Whether the diagnostic tests performed are recognized by the Professional Boards in the Division of Consumer Affairs, Department of Law and Public Safety, administered in accordance with their standards, and approved by the Commissioner at N.J.A.C. 11:3-4;
7. The necessity and appropriateness of consultation with other health care providers;
8. Disputes involving the application of, or adherence to, the automobile insurance medical fee schedule at N.J.A.C. 11:3-29;
9. Whether the treatment or service is reasonable, necessary and in accordance with medical protocols adopted by the Commissioner at N.J.A.C. 11:3-4; or
10. Amounts claimed for PIP income continuation benefits, essential services benefits, death benefits and funeral expense benefits.

“Provider” or “health care provider” is as defined at N.J.A.C. 11:3-4.2.

“Standard policy” means an automobile insurance policy including PIP coverage as provided in N.J.S.A. 39:6A-4.

“UCJF” means the Unsatisfied Claim and Judgement Fund created pursuant to N.J.S.A. 39:6-61 et seq.

11:3-5.3 Designation of the administrator

(a) The Commissioner shall designate a dispute resolution organization as the administrator of the PIP alternate dispute resolution system by entering into a contract with a dispute resolution organization.

(b) The contract designating the administrator shall be for a term not to exceed five years, but may be extended according to its terms until a new administrator is designated and substituted. Nothing in this subsection shall prohibit an administrator from succeeding itself, if so designated in accordance with N.J.S.A. 39:6A-5.1 and this subchapter.

The contract may provide for adjustments in the price paid for services performed over the life of the contract.

(c) The Commissioner shall request competitive proposals from among qualified dispute resolution organizations interested in serving as administrator.

(d) Dispute resolution organizations shall submit the following documents and information in connection with their proposal to serve as administrator:

1. A dispute resolution plan that describes how the organization shall meet the requirements of the Act and these rules, which shall include procedures and rules governing the dispute resolution process to ensure adherence to the standards of performance set forth in N.J.S.A. 39:6A-5.1 and 5.2 and this subchapter;

2. A description of the organization and biographical information about the key personnel that shall be responsible for executing the duties of the administrator;

3. A description of the management information systems that shall be utilized by the organization;

4. A draft budget for at least the first two years;

5. A cost proposal, which shall provide for the payment of the administrator's expenses, including the cost of dispute resolution professionals, from fees generated from the users of the system;

6. Such other information as may be provided by law, and that the Commissioner or the Treasurer may request in order to understand and evaluate the applicant's proposal.

11:3-5.4 Dispute resolution organizations

(a) In order to be eligible for designation as administrator, a dispute resolution organization shall meet the following criteria:

1. The dispute resolution organization shall not be owned or controlled by an insurer or affiliate of an insurer;

2. The dispute resolution organization shall utilize full-time dispute resolution professionals that meet the standards set forth in N.J.A.C. 11:3-5.5. For the purpose of this paragraph, "full-time" shall be construed to include persons who work fewer than five days per week, but who do not engage in other, conflicting employment;

3. The dispute resolution organization shall utilize an advisory council composed of parties who are users of the dispute resolution mechanism in connection with the selection of dispute resolution professionals and the periodic review of the organization's rules and processes;

4. The dispute resolution organization shall utilize procedures to avoid conflicts of interests as prohibited at N.J.A.C. 11:3-5.12;

5. The dispute resolution organization shall arrange for proceedings in locations reasonably convenient to the parties;

6. The dispute resolution organization shall maintain published rules for the conduct of the proceedings, and shall make them available to the parties and the public upon request;

7. The dispute resolution organization shall perform its functions in a prompt and efficient manner, giving due regard to the nature of the proceeding and the need for special attention when required by the exigencies of a particular matter; and

8. The dispute resolution organization shall provide sufficient oversight and training of its dispute resolution professionals so as to promote fair, efficient and consistent determinations consistent with substantive law and with rules adopted by the Commissioner.

(b) The dispute resolution organization shall develop and maintain a dispute resolution plan approved by the Commissioner that sets forth its procedures and rules. The dispute resolution plan shall be reviewed at least annually and revisions made upon approval by the Commissioner. The plan shall include the following elements:

1. The plan shall provide that PIP dispute resolution be initiated by written notice to the administrator and to all other parties of the party's demand for dispute resolution, which notice shall set forth concisely the claims, and where appropriate the defenses, in dispute and the relief sought. The notice shall include such other information as may be required for administrative purposes;

2. The plan shall provide for consolidation of claims into a single proceeding where appropriate in order to promote prompt, efficient resolution of PIP disputes consistent with fairness and due process of law;

3. The plan shall provide the assigned dispute resolution professional with sufficient authority to provide all relief and to determine all claims arising under PIP coverage, but may provide for limited, procedural or emergent matters to be determined by one or more specially designated dispute resolution professionals;

4. The plan shall provide for the assignment of a medical review organization to review the case and report its determination when requested pursuant to N.J.S.A. 39:6A-5.2 and this subchapter;

5. The plan shall provide for the prompt, fair and efficient resolution of PIP disputes, after a hearing by the assigned dispute resolution professional, but shall also provide that alternate procedures may be utilized when appropriate, which may include mediation, conferences to promote consensual resolution and expedited hearings upon receipt of a medical review organization report, consistent with principles of substantive law and rules adopted by the Commissioner; and

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) Determinations 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 or respondent 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.

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.

(b) The findings of a medical review organization shall be presumed to be correct, but may be rebutted by a preponderance of the evidence submitted to the dispute resolution professional.

11:3-5.9 Standards for medical review organizations

(a) Medical review organizations shall be capable of performing medical reviews for all primary specialties and disciplines.

(b) Medical review organizations shall employ a medical director to actively participate in the review of cases to assure quality and consistency.

(c) Medical review organizations shall utilize health care providers in the same discipline as the treating provider to perform the reviews who meet the following standards:

1. Reviewing health care providers shall be active practitioners who obtain a minimum of one-half of their income from practice in their area of specialty;

2. Reviewing health care providers shall be licensed in New Jersey and board certified in their specialty;

3. Reviewing health care providers shall have at least two years' experience in medical review, or be certified as a medical review physician; and

4. Reviewing health care providers shall have completed an orientation with the MRO, including medical review instruction and report writing.

(d) A medical review organization shall have adequate procedures in place to assure confidentiality of patient records.

1. All MRO files shall be indexed and referred to by reference number rather than patient name.

2. Medical files shall be maintained in a secure area of the MRO's offices.

3. Only the MRO shall request additional documents relating to the injured person's medical condition, or direct that the injured person be physically examined.

(e) A medical review organization shall utilize procedures to provide for the fair and open exchange of information and records related to the review between the treating health care provider, any provider that has reviewed the case on behalf of the insurer, and the MRO's reviewing health care provider.

(f) A medical review organization shall complete its review and submit its report to the dispute resolution professional in accordance with the medical exigencies of the case, but in no event in excess of 20 business days from receipt of medical records from the treating health care provider.

(g) A medical review organization shall have a procedure for obtaining mental or physical examinations of injured persons that may be required in the course of its review.

(h) A medical review organization shall utilize written review procedures. In reaching its determinations, the MRO shall consider all information submitted by the parties and information deemed appropriate by the MRO, including: pertinent medical records, consulting physician reports and other documents submitted by the parties; applicable commonly accepted protocols, professional standards and practices by national standard setting organizations, and protocols and diagnostic tests approved by the Commissioner and set forth in N.J.A.C. 11:3-4.

(i) A medical review organization shall utilize audit procedures to ensure compliance with statutory and regulatory requirements.

(j) A medical review organization shall retain records of its determinations for five years.

11:3-5.10 Medical review organization certification process

(a) The Commissioner shall certify a medical review organization to provide medical review services in connection with the resolutions of PIP disputes if the Commissioner determines that the MRO complies with the standards set forth in N.J.A.C. 11:3-5.9 to provide an impartial review of the medical necessity or appropriateness of treatments, health care services or items of durable medical equipment for which medical expense benefits may be provided under personal injury protection coverage.

(b) For the purpose of obtaining certification by the Commissioner to act as a medical review organization to perform medical review in connection with the resolution of PIP disputes, an MRO shall submit two copies of a written application that sets forth the information in (b) below to:

Medical Review Organization Certification
New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625-0325

(c) The MRO application shall include the following:

1. A list of the names, addresses and specialties of the individuals health care providers, that will provide the medical review services. If the MRO will be limited in its service area, the application shall provide a map of the service area, including the providers by specialty;

2. A copy of the MRO's certificate of incorporation and by-laws;

3. A diagram of the MRO's organizational structure;

4. The location of the MRO's place of business where it administers its services and maintains its records;

5. A listing and biography of the MRO's officers and directors, or the individuals in the organization responsible for administration of medical reviews, including the medical director;

6. A detailed description of the MRO's experience in the review of medical care;

7. A description of its procedures for review of medical treatments, diagnostic tests and items of durable medical equipment in conjunction with PIP medical expense benefits;

8. A current list identifying all property/casualty insurers, health insurers, health maintenance organizations and health care providers with whom the MRO maintains any health related business arrangement. The list shall include a brief description of the nature of the arrangement, so as to permit the administrator to avoid assignments that may create a conflict of interest;