

(g) Reports with an evaluation date of June 30 shall be due by July 31.

(h) Reports shall be submitted using the Excel templates, available on the Department's website at <http://www.state.nj.us/dobi> on one of the following media:

1. E-mail (preferred media);
2. CD-ROM; or
3. Floppy Diskette.

(i) The Excel templates shall not be modified by the user in any way.

(j) Reports shall be submitted to:

New Jersey Department of Banking and Insurance  
Office of Property and Casualty  
PO Box 325  
Trenton, NJ 08625-0325  
E-mail: [reports@dobi.state.nj.us](mailto:reports@dobi.state.nj.us)

Amended by R.2006 d.243, effective July 3, 2006.  
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

In (h), substituted "<http://www.state.nj.us/dobi>" for "<http://www.state.nj.us/dobi>".

Amended by R.2008 d.75, effective April 7, 2008.  
See: 39 N.J.R. 4538(a), 40 N.J.R. 1875(a).

In the introductory paragraph of (b), deleted "Tier Report;" following "Primary Classification;"; added new (b)1iii; recodified former (b)1iii and (b)1iv as (b)1iv and (b)1v; in (b)2i, deleted ", tier" following "classification"; deleted former (b)2ii; recodified former (b)2iii and (b)2iv as (b)2ii and (b)2iii; in (b)2ii, inserted "(three for SAIP)"; in (b)2iii, deleted "except to include extra tiers within the original spreadsheet for insurers who have additional tiers not listed on the template" following "any way"; and in (i), deleted "except as stated above in (b)2iv above" following "any way".

#### 11:3-3A.4 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties pursuant to N.J.S.A. 17:33-2 and as otherwise authorized by law.

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

#### 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 and emergency personal injury protection coverage for which reimbursement of eligible charges will be made by automobile insurers under basic, standard and special automobile insurance 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, emer-

gency personal injury protection 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.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

In (a), inserted "and emergency personal injury protection coverage" following "medical expense benefits"; deleted "and" following "automobile insurers under basic"; inserted "and special automobile insurance" preceding "policies and by motor bus insurers"; in (b), inserted "emergency personal injury protection coverage" following "automobile insurance containing PIP coverage".

#### Case Notes

Statute and the regulations promulgated by the Commissioner represented a complex legislative and regulatory package designed to reform automobile insurance law in New Jersey, and the courts of New Jersey were in the best position to consider the validity of the applicable regulations under state law. *Chiropractic America v. Lavachchia*, 180 F.3d 99 (3rd Cir. N.J. 1999).

Uninsured passenger, not qualified to receive Medicaid, who receives emergency personal injury protection benefits under the driver's special automobile insurance policy is entitled to personal injury protection coverage from the Unsatisfied Claim and Judgment Fund for non-emergency medical treatment. *Sanders v. Langemeier*, 401 N.J. Super. 125, 949 A.2d 295, 2008 N.J. Super. LEXIS 134 (App.Div. 2008).

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. *Quality Health Care v. DOBI*, 348 N.J. Super. 272, 791 A.2d 1085.

#### 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.

"Clinically supported" means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
2. Physically examined the patient including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests;
3. Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and

4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

"Decision point" means those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths where a decision must be made about the continuation or choice of further treatment. The determination whether to administer one of the tests listed in N.J.A.C. 11:3-4.5(b) is also a decision point for both identified and all other injuries.

"Decision point review" means the procedures in an insurer's approved decision point review plan for the insurer to receive notice and respond to requests for proposed treatment or testing at decision points.

"Diagnostic test" means a medical service or procedure utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical, dental, physical therapy, chiropractic or psychological diagnosis, for the purpose of recommending or developing a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

"Eligible charge" means the treating health care provider's usual, customary and reasonable charge or the upper limit of the medical fee schedule as found in N.J.A.C. 11:3-29.6, whichever is lower.

"Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity 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 medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization 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. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident.

"Emergency personal injury protection coverage" means the coverage provided by a Special Automobile Insurance Policy pursuant to section 45 of P.L. 2003, c.89.

"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 that is maintained by State or any political subdivision;
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 radiological and diagnostic testing, free-standing emergency clinics or offices, and private treatment centers;

4. A nonprofit voluntary visiting nurse organization providing health care services other than 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 bioanalytical laboratories;

13. Licensed psychologists;

14. Licensed physical therapists;

15. Certified nurse mid-wives;

16. Certified nurse practitioners/clinical nurse-specialist;

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 physicians assistants;

24. Licensed physical therapy assistants;

25. Licensed occupational therapy assistants; and

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

"Identified injury" means those injuries identified by the Department in the subchapter Appendix as being suitable for medical treatment protocols in accordance with N.J.S.A. 39:6A-3.1a and 39:6A-4a.

"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. Insurer does not include an entity that is self-insured pursuant to N.J.S.A. 39:6-52. For purposes of communicating with insureds and providers concerning the administration of decision point review plans, "insurer" also means the insurer's PIP vendor.

“Medical expense” means the reasonable and necessary expenses for treatment or services rendered by a provider, including medical, surgical, rehabilitative and diagnostic services and hospital expenses and reasonable and necessary expenses for ambulance services or other transportation, medication and other services, subject to limitations as provided for in the policy forms that are filed and approved by the Commissioner.

“Medically necessary” or “medical necessity” means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths in the Appendix, as applicable;
2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
3. Does not include unnecessary testing or treatment.

“Network” means an entity other than an insurer that contracts with providers to render health care services or provide supplies at predetermined fees or reimbursement levels.

“Non-medical expense” means charges for those:

1. Products and devices, not exclusively used for medical purposes or as durable medical equipment, such as any vehicles, durable goods, equipment, appurtenances, improvements to real or personal property, fixtures; and
2. Services and activities such as recreational activities, trips and leisure activities.

“PIP vendor” means a company used by an insurer to administer its decision point review plan.

“Precertification” or “precertification request” means the procedures in an insurer’s approved decision point review plan for the insurer to receive notice and respond to requests for listed 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.

“Standard automobile insurance policy” or “standard policy” means a private passenger automobile insurance policy issued in accordance with N.J.S.A. 39:6A-4.

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

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

Inserted “Diagnostic test”.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote “Decision point”, added “Decision point review”, “Emergency personal injury protection coverage”, “Insurer”, “Network”, “PIP vendor” and rewrote “Pre-certification”.

#### Case Notes

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. *Quality Health Care v. DOBI*, 348 N.J.Super. 272, 791 A.2d 1085.

#### 11:3-4.3 Personal injury protection benefits applicable to basic and standard policies

(a) Personal injury protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident up to the limits set forth in the policy and in accordance with this subchapter.

(b) Personal injury protection coverage shall only provide reimbursement for clinically supported necessary non-medical expenses that are prescribed by a treating medical provider for a permanent or significant brain, spinal cord or disfiguring injuries.

#### 11:3-4.4 Deductibles and co-pays

(a) Each insurer shall offer a standard \$250.00 deductible and 20 percent copayment on medical expense benefits payable between \$250.00 and \$5,000.

(b) Each insurer shall also offer, at appropriately reduced premiums, the option to select medical expense benefit deductibles of \$500.00, \$1,000, \$2,000 and \$2,500 in accordance with the following provisions:

1. Any medical expense deductible elected by the named insured shall apply only to the named insured and any resident relative in the named insured’s household, who is not a named insured under another automobile policy and not to any other person eligible for personal injury protection benefits required to be provided in accordance with N.J.S.A. 39:6A-3.1 and 39:6A-4;

2. Premium credits calculated and represented as a percentage of the applicable premium shall be provided for each deductible. The premium percentage shall be uniform by filer on a statewide basis; and

3. The deductible option elected by the named insured shall continue in force as to subsequent renewal or replacement policies until the insurer or its authorized representative receives a properly executed coverage selection form to eliminate or change the deductible.

(c) All deductibles and co-pays in (a) and (b) above shall apply on a per accident basis.

(d) Failure to request decision point review or precertification where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time

notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

Example: Assume that all days are business days and the insurer's Decision Point Review Plan gives the insurer three days to respond to decision point review and precertification requests. By the terms of the insurer's Decision Point Review Plan, a treating medical provider is required to make a decision point review request on day 21 of treatment (time notification was required). The provider does not give the required notification in a timely manner but continues to treat the patient. The provider then makes the notification and it is received by the insurer on day 35 (time proper notification made). The insurer responds on day 38 that the treatment can proceed (time for insurer to respond). Assuming that the treatment made between day 21 and 38 was medically necessary, it is subject to the 50 percent co-payment.

1. 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 review plan to request further information, modify or deny reimbursement of further treatment, diagnostic tests or durable medical equipment.

(e) An insurer may require that the insured advise and inform the insurer about the injury and the claim. This requirement may include the production of information from the insured regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment.

1. This information may be required to be provided as promptly as possible after the accident, and periodically thereafter.

2. An insurer may impose an additional co-payment as a penalty for failure to supply the required information. Such penalties shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. The additional co-payment shall be an amount no greater than:

- i. Twenty-five percent when received 30 or more days after the accident; or
- ii. Fifty percent when received 60 or more days after the accident.

3. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

4. Information about this requirement and how to comply with it shall be included in the informational materials required by N.J.A.C. 11:3-4.7(d).

(f) An insurer may impose an additional co-payment not to exceed 30 percent of the eligible charge for failure to use

an approved network pursuant to N.J.A.C. 11:3-4.8 for medically necessary diagnostic tests as specified in N.J.A.C. 11:3-4.8(b), durable medical equipment and/or prescriptions.

(g) For the purpose of the co-payments permitted in (d), (e) and (f) above, the percentage reduction shall be applied to the amount that the insurer would otherwise have paid to the insured or the provider after the application of the provisions of N.J.A.C. 11:3-29. Insurers may apply the co-payments and deductibles in (a) through (f) above in any order, provided that they use the same order of application for all insureds. Upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall make its co-payment and deductible application methodology available to the insured and the treating medical provider upon request.

(h) For private passenger automobiles insured under a commercial automobile insurance policy where no natural person is a named insured, insurers shall only provide personal injury protection with medical expense benefits coverage in an amount not to exceed \$250,000 per person, per accident, with the deductible and copayment amount set forth in (a) above.

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

Inserted a new (e); and recodified former (e) as (f).  
Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote (d); added (f); recodified former (f) as (h).  
Amended by R.2004 d.218, effective June 7, 2004 (operative March 4, 2005).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Rewrote (g).  
Amended by R.2008 d.46, effective March 3, 2008.  
See: 39 N.J.R. 4056(a), 40 N.J.R. 1353(a).

In (g), substituted the last two sentences for "Such amount may have already been reduced by the application of the co-payments and/or deductibles in (a) and (b) above."

#### 11:3-4.5 Diagnostic tests

(a) The personal injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, which have been determined to yield no data of any significant value in the development, evaluation and implementation of an appropriate plan of treatment for injuries sustained in motor vehicle accidents:

1. (Reserved)
2. Spinal diagnostic ultrasound;
3. Iridology;
4. Reflexology;
5. Surrogate arm mentoring;
6. Surface electromyography (surface EMG);
7. (Reserved); and
8. Mandibular tracking and stimulation.

(b) The personal injury protection medical expense benefits coverage shall provide for reimbursement of the following diagnostic tests, which have been determined to have value in the evaluation of injuries, the diagnosis and develop-

ment of a treatment plan for persons injured in a covered accident, when medically necessary and consistent with clinically supported findings:

1. Needle electromyography (needle EMG) when used in the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling. A needle EMG is not indicated in the evaluation of TMJ/D and is contraindicated in the presence of infection on the skin or cellulitis. This test should not normally be performed within 14 days of the traumatic event and should not be repeated where initial results are negative. Only one follow up exam is appropriate.

2. Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex Study are reimbursable when used to evaluate neuropathies and/or signs of atrophy, but not within 21 days following the traumatic injury.

3. Electroencephalogram (EEG) when used to evaluate head injuries, where there are clinically supported findings of an altered level of sensorium and/or a suspicion of seizure disorder. This test, if indicated by clinically supported findings, can be administered immediately following the insured event. When medically necessary, repeat testing is not normally conducted more than four times per year.

4. Videofluoroscopy only when used in the evaluation of hypomobility syndrome and wrist/carpal hypomobility, where there are clinically supported findings of no range or aberrant range of motion or dysmmetry of facets exist. This test should not be performed within three months following the insured event and follow up tests are not normally appropriate.

5. Magnetic resonance imaging (MRI) when used in accordance with the guidelines contained in the American College of Radiology, Appropriateness Criteria to evaluate injuries in numerous parts of the body, particularly the assessment of nerve root compression and/or motor loss. MRI is not normally performed within five days of the insured event. However, clinically supported indication of neurological gross motor deficits, incontinence or acute nerve root compression with neurologic symptoms may justify MRI testing during the acute phase immediately post injury. In the case of TMJ/D where there are clinical signs of internal derangement such as nonself-induced clicking, deviation, limited opening, and pain with a history of trauma to the lower jaw, an MRI is allowable to show displacement of the condylar disc, such procedure following a panoramic or transcranial x-ray and six or eight weeks of conservative treatment. This TMJ/D diagnostic test may be repeated post surgery and/or post appliance therapy.

6. Computer assisted tomographic studies (CT, CAT Scan) when used to evaluate injuries in numerous aspects of the body. With the exception of suspected brain injuries, CAT Scan is not normally administered immediately post

injury, but may become appropriate within five days of the insured event. Repeat CAT Scans should not be undertaken unless there is clinically supported indication of an adverse change in the patient's condition. In the case of TMJ/D where there are clinical signs of degenerative joint disease as a result of traumatic injury of the temporomandibular joint, tomograms may not be performed sooner than 12 months following traumatic injury.

7. Dynatron/cyber station/cybex when used to evaluate muscle deterioration or atrophy. These tests should not be performed within 21 days of the insured event and should not be repeated if results are negative. Repeat tests are not appropriate at less than six months intervals.

8. Sonograms/ultrasound when used in the acute phase to evaluate the abdomen and pelvis for intra-abdominal bleeding. These tests are not normally used to assess joints (knee and elbow) because other tests are more appropriate. Where MRI is performed, sonograms/ultrasound are not necessary. However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

9. Thermography/thermograms only when used to evaluate pain associated with reflex sympathetic dystrophy ("RSD"), in a controlled setting by a physician experienced in such use and properly trained.

10. Brain mapping, when done in conjunction with appropriate neurodiagnostic testing.

(c) The terms "normal," "normally," "appropriate" and "indicated" as used in (b) above, are intended to recognize that no single rule can replace the good faith educated judgment of a health care provider. Thus, "normal," "normally," "appropriate" and "indicated" pertain to the usual, routine, customary or common experience and conclusion, which may in unusual circumstances differ from the actual judgment of course of treatment. The unusual circumstances shall be based on clinically supported findings of a health care provider. The use of these terms is intended to indicate some flexibility and avoid rigidity in the application of these rules in the decision point review required in (d) below.

(d) Except as provided in (e) below, a determination to administer any of the tests in (b) above shall be subject to decision point review pursuant to N.J.A.C. 11:3-4.7.

(e) The requirements of (b) and (d) above shall not apply to diagnostic tests administered during emergency care.

(f) Pursuant to N.J.A.C. 13:30-8.22(b), the personal injury protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

1. Mandibular tracking;

2. Surface EMG;
3. Sonography;
4. Doppler ultrasound;
5. Needle EMG;
6. Electroencephalogram (EEG);
7. Thermograms/thermographs;
8. Video fluoroscopy; and
9. Reflexology.

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

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

In (a), deleted a former 6, and recodified former 7 through 9 as 6 through 8; in (b), substituted a reference to infections for a reference to staph infections in 1, added fourth and fifth sentences in 5, rewrote 6, deleted a former fourth sentence in 8, and added 9 and 10; in (c), substituted references to health care providers for references to trained medical professionals throughout; and added new (f).

#### 11:3-4.6 Medical protocols

(a) Pursuant to N.J.S.A. 39:6A-3.1 and 39:6A-4, the Commissioner designates the care paths, set forth in the subchapter Appendix incorporated herein by reference, as the standard course of medically necessary treatment, including diagnostic tests, for the identified injuries.

(b) Where the care path indicates a decision point either by a hexagon in the care path itself or by reference in the text to a second opinion, referral for a second independent consultative medical opinion, development of a treatment plan or mandatory case management, the policy shall provide for a decision point review in accordance with N.J.A.C. 11:3-4.7.

(c) Treatments that vary from the care paths shall be reimbursable only when warranted by reason of medical necessity.

(d) The care paths do not apply to treatment administered during emergency care.

#### Law Review And Journal Commentaries

What's Next for No Fault? Gerald H. Baker, 159 N.J.L.J. 267 (2000).

#### 11:3-4.7 Decision point review plans

(a) No insurer shall impose the co-payments permitted in N.J.A.C. 11:3-4.4(d), (e) and (f) unless it has an approved decision point review plan.

1. Initial decision point review plan filings and amendments to approved plans shall be submitted to the Department through the use of the NAIC electronic filing system SERFF (System for Electronic Rate and Form Filing).

(b) No decision point or precertification requirements shall apply within 10 days of the insured event or to emergency care. This provision should not be construed so as to require

reimbursement of tests and treatment that are not medically necessary.

(c) A decision point review plan filing shall include the following information:

1. Identification of any PIP vendor with which the insurer has contracted. PIP vendors shall designate a New Jersey licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that decision point review and precertification requests are based upon medical necessity in accordance with the requirements of this subchapter;

2. Identification of any specific medical procedures, treatments, diagnoses, diagnostic tests, other services or durable medical equipment that are subject to precertification. The inclusion of precertification requirements in a decision point review plan is optional. The medical procedures, treatments, diagnoses, diagnostic tests or durable medical equipment required to be precertified shall be those that the insurer has determined may be subject to overutilization and that are not already subject to decision point review;

3. Copies of the informational materials described in (d) below and an explanation of how the insurer will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim. An insurer shall make its informational materials available on the World Wide Web and provide the URL and any changes thereto to the Department's webmaster at: [webmaster@dobi.state.nj.us](mailto:webmaster@dobi.state.nj.us);

4. Procedures for the prompt review, not to exceed three business days, of decision point review and precertification requests by insureds or providers. All determinations on treatments or tests shall be based on medical necessity and shall not encourage over or underutilization of benefits. Denials of decision point review and precertification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist;

5. Procedures for the scheduling of physical examinations pursuant to (e) below;

6. An internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or the administration of a test;

7. Reasonable restrictions on the assignment of benefits pursuant to N.J.A.C. 11:3-4.9(a); and

8. The information required in order to use a network pursuant to N.J.A.C. 11:3-4.8(d), if applicable.

(d) The informational materials for policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the informa-

tion in (d)1 through 9 below. In order to make the requirements of this subchapter easier for insureds and providers to use, the Commissioner may by Order require the use of uniform forms, layouts and language of information materials.

1. How to contact the insurer or vendor to submit decision point review/precertification requests including the telephone, facsimile numbers or email addresses. The insurer or its vendor shall be available, at a minimum, during normal working hours to respond to decision point review/precertification requests;

2. An explanation of the decision point review process including a list of the identified injuries and the diagnostic tests in N.J.A.C. 11:3-4.5(b). The materials shall include copies of the Care Paths or indicate how copies may be obtained;

3. A list of the medical procedures, treatments, diagnoses, diagnostic tests, durable medical equipment or other services that require precertification, if any;

4. An explanation of how the insurer will respond to decision point review/precertification requests, including time frames. The materials should indicate that:

i. Telephonic responses will be followed up with a written authorization, denial or request for more information within three business days;

5. An explanation of the insurer's option to require a physical examination pursuant to (e) below;

6. An explanation of the penalty co-payments imposed for the failure to submit decision point review/precertification requests where required in accordance with N.J.A.C. 11:3-4.4(d);

7. An explanation of the insurer's voluntary network or networks for certain types of testing, durable medical equipment or prescription drugs authorized by N.J.A.C. 11:3-4.8, if any;

8. An explanation of the alternatives available to the provider if reimbursement for a proposed treatment, diagnostic test or durable medical equipment is denied or modified, including insurer's internal appeal process and how to use it; and

9. An explanation of the insurer's restrictions on assignment of benefits, if any.

(e) A physical examination of the injured party shall be conducted as follows:

1. The insurer shall notify the injured person or his or her designee that a physical examination is required to determine the medical necessity of further treatment, diagnostic tests or durable medical equipment. An insurer shall include reasonable procedures for the notification of the injured person and the treating medical provider where reimbursement of further treatment, diagnostic testing or

durable medical equipment will be denied for failure to appear at scheduled medical examinations.

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

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

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

5. The 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 at the time of the examination or before.

6. The insurer shall notify the injured person or his or her designee and the treating medical provider whether it will reimburse for further treatment, diagnostic tests or durable medical equipment as promptly as possible but in no case later than three business 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.

7. Insurers may include in their decision point review plan a procedure for the denial or reimbursement for treatment, diagnostic testing or durable medical equipment after repeated unexcused failure to attend a scheduled physical examination. The procedure shall provide for adequate notification of the insured and the treating provider of the consequences of failure to attend the examination.

(f) In administering decision point review and precertification, insurers shall avoid undue interruptions in a course of treatment. As part of their decision point review plans, insurers may include provisions that encourage providers to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries to minimize the need for piecemeal review. An agreed comprehensive treatment plan may replace the requirements for notification to the insurer at decision points and for treatment, diagnostic testing or durable medical equipment requiring precertification. In addition, the insurer may provide that reimbursement for treatment, diagnostic tests or durable medical equipment consistent with the agreed plan will be made without review or audit.

(g) An insurer shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless the request involved fraud or misrepresentation, as defined in N.J.A.C. 11:16-6.2, by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

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).  
Repeal and New Rule, R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Section was "Decision point review".

Amended by R.2006 d.243, effective July 3, 2006.

See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

In (e)7, substituted "decision" for "description"; and in (g), substituted "N.J.A.C. 11:16-6.2" for "N.J.A.C. 11:16-16.2".

Amended by R.2009 d.190, effective June 15, 2009.

See: 41 N.J.R. 365(a), 41 N.J.R. 2486(a).

Rewrote (a)1.

### 11:3-4.8 Voluntary networks

(a) No insurer shall file a decision point review plan utilizing a voluntary network or networks unless the network is a health maintenance organization licensed pursuant to N.J.S.A. 26:2J-1 et seq.; or approved by the Department as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37 and 8:38A-4.10; or approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6, or is licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 and 8:38B.

(b) Voluntary networks may be offered for the provision of the following types of non-emergency benefits only:

1. Magnetic Resonance Imagery;
2. Computer Assisted Tomography;
3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs performed by the treating physician;
4. Durable medical equipment with a cost or monthly rental in excess of \$50.00; or
5. Prescription drugs.

(c) Insurers that offer voluntary networks either directly or through a PIP vendor shall meet the following requirements:

1. The insurer shall notify all insureds upon application for and issuance of the policy and upon renewal of the types of benefits for which it has voluntary networks. Use of the network by the insured is voluntary but bills for out-of-network services or equipment are subject to the penalty deductibles set forth in N.J.A.C. 11:3-4.4(f).
2. Upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall make available to the insured and the treating medical provider information about approved networks and providers in the network,

including addresses and telephone numbers. Insureds shall be able to choose to go to any provider in the network.

(d) An insurer offering a voluntary network or networks directly or through a PIP vendor shall submit the following information to the Department with its Decision Point Review Plan:

1. A narrative description of the benefits to be offered through the network or networks;
2. The identity and a description of the network and the specific services or supplies to be provided by the network or networks;
3. A description of the procedures by which benefits may be obtained by persons using the network; and
4. A statement of how the network meets the requirement of (a) above.

(e) Any voluntary network used by an insurer pursuant to this subchapter shall agree to disclose to a participating provider, upon written request, a list of all the clients or other payers that are entitled to a specific rate under the network's contract with the participating provider.

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.

Repeal and New Rule, R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

Section was "Precertification".

### 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. Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:

1. A requirement that as a condition of assignment, the provider agrees to follow the requirements of the insurer's decision point review plan for making decision point review and precertification requests;
2. A requirement that as a condition of assignment, the provider shall hold the insured harmless for penalty co-payments imposed by the insurer based on the provider's failure to follow the requirements of the insurer's Decision Point Review Plan; and/or
3. A requirement that as a condition of assignment, the provider agrees to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

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 Commis-

sioner 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 of 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.

Amended by R.2006 d.243, effective July 3, 2006.  
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).  
Substituted "years of" for "years" in (a)1.

### 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.

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.

(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".

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.

#### 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.

(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 individual 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;
9. Such other information as the Commissioner may specifically request in connection with the certification of a particular applicant; and
10. A fee in the amount of \$1,000 payable to the Department of Banking and Insurance.

(d) The materials specified in (c) above shall be retained by the Department and may be referred to the Department of Health and Senior Services for consultation as necessary. Any

significant changes in the materials filed with the Department shall be reported as an amendment to the materials filed within 30 days of the change.

(e) The Department, in consultation with the Department of Health and Senior Services, shall review the materials and grant or deny certification within 45 days of receipt of a complete filing. The Commissioner may extend the time an additional 30 days for good cause shown, and shall notify the applicant of any extension. A decision to deny certification shall be in writing and include an explanation of the reason for the denial.

(f) Initial certification shall be effective for a period of two years. Certified MROs shall reapply for certification 90 days prior to expiration by submitting the items set forth in (b)1, 6, 7, 8, 9 and 10 above and any changes to items previously submitted in (b)2, 3, 4 and 5 above. Renewal certification may be effective for a period of up to five years.

(g) All data or information in the MRO's application for certification shall be confidential and shall not be disclosed to the public, except as follows:

1. The MRO's certificate of incorporation;
2. The MRO's address;
3. The names of the MRO's officers and directors, or the individuals in the organization responsible for the administration of medical reviews including the medical director; and
4. The date of certification of the MRO and date that certification expires.

(h) Upon certification, the Department shall advise the administrator of the name and address of the MRO, any limitations on its geographical service area and information about persons with whom it maintains health related business arrangements.

(i) The Commissioner may suspend or revoke the certification of an MRO upon finding that the MRO no longer meets the standards set forth in N.J.A.C. 11:3-5.9; that medical review services are not being provided in accordance with the requirements of this subchapter; or that the certification was granted based on false or misleading information.

1. Proceedings to revoke or suspend the certification shall be conducted pursuant to N.J.A.C. 11:17D.
2. Upon request of the MRO for a hearing, the matter shall be transferred to the Office of Administrative Law for a hearing conducted pursuant to the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

Amended by R.2006 d.243, effective July 3, 2006.

See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

In (c)1, substituted "individuals" for "individuals" and deleted a comma following "providers".

**11:3-5.11 Fees**

(a) The initial fee for a determination by a Medical Review Organization shall be \$575.00. The Commissioner may adjust the fee every two years by order based on the rise in the medical component of the Consumer Price Index as published by the United States Department of Labor. Such fee adjustments shall be initiated in this subchapter through a notice of administrative change published in the New Jersey Register.

(b) When a mental or physical examination is performed in connection with the medical review organization's services, the health care provider performing the examination shall be paid the fee provided for that service set forth on the Department's medical fee schedule, N.J.A.C. 11:3-29.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).  
See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).  
Rewrote (a).

**11:3-5.12 Prohibition of conflicts of interest**

(a) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall have any personal or financial interest, direct or indirect, or engage in any business or transaction which is in conflict with the proper conduct of his or her duties under this subchapter.

(b) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall act in such capacity in any matter wherein he or she has a direct or indirect personal or financial interest that might reasonably be expected to impair his or her objectivity or independence of judgment.

(c) No administrator or employee thereof, dispute resolution professional, medical review organization or reviewing health care provider shall accept any gift, favor, service or other thing of value under circumstances from which it might be reasonably inferred that such gift, service or other thing of value was given or offered for the purpose of influencing him or her in the conduct of duties under this subchapter.

(d) No dispute resolution professional shall accept from any person, whether directly or indirectly and whether by him or herself or through a spouse or any family member or through any partner or associate or controlled business, any gift, favor, service, employment or offer of employment or any other thing of value which he or she knows or has reason to believe is offered with the intent to influence the performance of his or her duties as a dispute resolution professional.

(e) No dispute resolution professional shall make any determination in any PIP dispute in which he or she directly or indirectly or through a spouse, family member or by partner or associate or controlled business has any personal or financial interest.

**SUBCHAPTER 6. INSURANCE IDENTIFICATION CARDS****11:3-6.1 Scope**

In accordance with N.J.S.A. 39:3-29.1, this subchapter concerns the issuance, design and content of auto insurance identification cards issued by insurance companies in this State. This subchapter shall not apply to policies covering commercial motor vehicles regulated by the U.S. Department of Transportation or the New Jersey Board of Public Utilities.

As amended, R.1983 d.648, effective January 17, 1984.  
See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).  
Reference to dates deleted.  
Amended by R.2004 d.166, effective April 19, 2004.  
See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).  
Rewrote the section.

**Case Notes**

Policy provision defining an eligible person as a spouse only if resident in the same household as insured held void; named insured's deletion of estranged wife; reformation of policy ordered. *Matland v. United Services Automobile Ass'n*, 174 N.J.Super. 499, 417 A.2d 46 (Law Div.1980).

**11:3-6.2 Permanent identification cards**

(a) A permanent insurance identification card shall conform to the following specifications:

1. The minimum size shall be three inches by five inches, and the maximum size shall be 5½ inches by 8½ inches.
2. The weight shall not be lighter than 20 pounds white bond.
3. The front of the card shall include the following:
  - i. The company name: Group name may be shown instead if it will identify the specific company involved. Insurance company logos are permitted;
  - ii. Named insured: The surname of the insured must agree with the surname shown on the motor vehicle registration certificate. The Motor Vehicle Commission will conduct verification on surname basis;
  - iii. Address: The replacement of identification cards when there is a change of address will be optional with the insurance companies;
  - iv. Policy number: The complete policy number will be listed;
  - v. Effective date and expiration date: month, day, and year.
  - vi. Description of the vehicle: Year, make and vehicle identification number shall be noted on the insurance identification card. The model of the vehicle may be shown as the make. The make of the vehicle may be abbreviated, but the complete vehicle identification number (VIN) must be shown.

vii. In the case of fleets, dealership or leasing companies where the owner insures the vehicles, the make, year and VIN need not be recorded. In lieu of the make, year and VIN, the insurer may insert "ALL OWNED VEHICLES" or "FLEET". If the lessee insures the vehicles, the name of the owner as shown on the motor vehicle registration must be shown on the I.D. card in addition to the name of the insured if the designation "FLEET" is used without the VIN;

viii. Heading: The heading across the top shall read: State of New Jersey Insurance Identification Card;

ix. The insurance company code as established by the New Jersey Motor Vehicle Commission will be printed immediately preceding the insurance company name;

x. The name and address of the insurance company or the office or agency issuing the identification cards must be shown.

4. The reverse of card shall include the address, and may include a facsimile number and E-mail address, if any, established by the insurer for the filing of notification of the commencement of medical treatment by treating medical providers under N.J.A.C. 11:3-25. This information shall be provided under the following title: "ADDRESS FOR NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT"

5. This notice may be placed on the front or reverse of the identification card and may be printed on the card or affixed on the card by way of a label that contains the required information.

(b) Servicing carriers of any residual market mechanism authorized by statute shall issue an insurance identification card in accordance with (a) above. The card shall indicate that coverage is being issued by the servicing carrier on behalf of the residual market mechanism.

As amended, R.1973 d.140, eff. May 31, 1973.

See: 5 N.J.R. 150(a), 5 N.J.R. 229(b).

As amended, R.1973 d.247, eff. August 31, 1973.

See: 5 N.J.R. 350(b).

As amended, R.1983 d.648, eff. January 17, 1984.

See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Further specifications for ID cards added and alternative type of card introduced.

Amended by R.1991 d.45, effective February 4, 1991.

See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

In (d): deleted NJAFIUA reference and added text referring to "residual market mechanism authorized by statute."

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.14, effective January 6, 1997 (operative March 7, 1997).

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

Added (b)5 and (b)6.

Amended by R.2004 d.166, effective April 19, 2004.

See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).

Deleted former (a) and (c); recodified former (b) as new (a); recodified former (d) as new (b); rewrote new (a).

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)3ii and ix, substituted "Motor Vehicle Commission" for "Division of Motor Vehicles"; and in (a)3ii, inserted "the" preceding "surname".

#### Case Notes

Policy provision defining an eligible person as a spouse only if resident in the same household as insured held void; named insured's deletion of estranged wife from coverage held void; reformation of policy ordered. *Matland v. United Services Automobile Ass'n*, 174 N.J.Super. 499, 417 A.2d 46 (Law Div.1980).

### 11:3-6.3 Temporary identification card

(a) The format and content of the temporary card shall be the same as those for a permanent identification card except as noted below.

1. Title: "TEMPORARY" to precede heading on card;
2. Policy number: Indicate policy number if available; otherwise, the application or binder number is acceptable;
3. Effective date: Month, day and year that coverage becomes effective. Expiration date is not required;
4. Expiration: The card shall contain the following statement: "This card expires 60 days after the effective date shown above";

As amended, R.1973 d.35, eff. January 26, 1973.

See: 5 N.J.R. 20(b).

As amended, R.1974 d.208, eff. July 24, 1974.

See: 6 N.J.R. 322(b).

As amended, R.1983 d.648, eff. January 17, 1984.

See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Language changes and clarification.

Amended by R.1991 d.45, effective February 4, 1991.

See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Deleted subsection (b), describing components of the New Jersey Automobile Insurance Plan.

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.2004 d.166, effective April 19, 2004.

See: 35 N.J.R. 3521(a), 36 N.J.R. 1939(a).

Rewrote the section.

### 11:3-6.4 General provisions

(a) The order of the information to be contained on the identification cards may be rearranged in order to accommodate fixed printout systems already established by a company.

(b) Additional information may be printed on the reverse side of the identification cards, provided the additional information is appropriately captioned and is not at variance with the information required.

(c) One identification card shall be issued for each vehicle insured under the policy. Replacement identification card or cards will be issued at the request of the insured in the event of loss.