

DECISION POINT REVIEW PLAN REQUIREMENTS

IMPORTANT INFORMATION For Licensed Health Care Providers About No-Fault Medical Coverage (Also Known as Personal Injury Protection or PIP)

The Automobile Insurance Cost Reduction Act became law in May 1998 and established certain obligations which must be satisfied so that coverage for medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident may be provided. Failure to abide by the following obligations may affect the authorization of medical treatment, diagnostic testing and durable medical equipment.

1. Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, **care paths**, for injuries of the neck or back, collectively referred to as the **identified injuries**. The **care paths** provide that treatment be evaluated at certain intervals called **decision points**. At **decision points**, we must be provided with information about further treatment which is intended to be undertaken. This is called **decision point review**. Information is also available on the Web site of the Department of Banking and Insurance, <http://www.nj.gov/dobi/aicrapg.htm>, or by calling the Claims Representative. If you fail to submit requests for **decision point review** or fail to submit legible clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested, payment of medical bills may be subject to a penalty co-payment of up to 50% even if the services are later determined to be medically necessary.
2. If you consider certain diagnostic testing to be medically necessary, this also requires **decision point review** per N.J.A.C. 11:3-4, regardless of diagnosis, and we must be provided with written support establishing the need for the test before we can consider authorizing it. The list of diagnostic tests requiring our prior authorization and a list of diagnostic tests which the law prohibits us from authorizing under any circumstances is also included in this information packet. If diagnostic testing requests are not submitted for **decision point review** or if you fail to submit legible clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested, payment may be subject to a penalty co-payment of up to 50% even if the services are later determined to be medically necessary.
3. In accordance with N.J.A.C. 11:3-4.8 the plan includes a voluntary network for:
 1. Magnetic Resonance Imagery;
 2. Computer Assisted Tomography; and
 3. Electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3, except when performed in conjunction with a needle EMG by the treating physician.

When one of the services listed above is authorized through the **decision point review** or **precertification** process, information about voluntary network providers will be supplied to the claimant or requesting provider. A list of network providers will be available on the Company's Web site at www.NJM.com/network or by contacting the appropriate claims representative.

Those individuals who choose not to utilize the network will be assessed an additional co-payment not to exceed 30% of the eligible charge. That co-payment will be the responsibility of the claimant.

4. For treatment, diagnostic testing or durable medical equipment not included in the **care paths** or subject to **decision point review** pursuant to N.J.A.C. 11:3-4, you or our insured are required to obtain our **precertification** for the following services and/or conditions: Non-emergency inpatient or outpatient hospital care (including the appropriateness and duration of the hospital stay); Non-emergency surgery (performed in a hospital, freestanding surgical center, office, etc.); Durable medical equipment (including orthotics and prosthetics) costing greater than \$50, or rental greater than 30 days; Extended care and rehabilitation; Home health care; Infusion therapy; Outpatient psychological/psychiatric testing and/or services

including biofeedback; All physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation; All pain management services; Non-emergency dental restoration; Temporomandibular disorders or any oral facial syndrome; Outpatient care for soft tissue/disc injuries of the insured's neck, back or related structures not included within the diagnoses covered by the **care paths**; Computerized muscle testing; Current perceptual testing; Temperature gradient studies; Work hardening; Carpal Tunnel Syndrome; Vax D; Podiatry; Audiology; and Bone Scans.

The failure to seek **precertification** for such services or the failure to submit legible clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested could result in the imposition of a 50% co-payment penalty even if the services are later determined to be medically necessary.

5. We encourage the submission of comprehensive treatment plans to avoid periodic reviews when continued treatment is considered medically necessary for an extended period of time. You or our insured must submit a request for **decision point review** or **precertification** for any treatment or testing that varies from the approved treatment plan.
6. Upon receipt of proper written documentation in accordance with **decision point review** requirements of paragraphs one and two and the **precertification** requirements as specified in paragraph four, we will either:
 - a. Authorize the treatment, diagnostic testing or durable medical equipment;
 - b. Deny and/or modify the treatment, diagnostic testing or durable medical equipment;
 - c. Request additional medical documentation; or
 - d. Advise that an Independent Medical Examination will be scheduled.

If we fail to do at least one of these four things within three business days, the proposed treatment, diagnostic testing and/or durable medical equipment is deemed to be authorized until a final determination is communicated to you. Telephonic responses will be followed up with a written authorization, denial or request for more information within three business days. The decision to deny a request based on medical necessity will be made by a physician or a dentist.

If an Independent Medical Examination (IME) is required to determine the medical necessity of further treatment, diagnostic testing or durable medical equipment, we will schedule an appointment within seven (7) calendar days of receipt of the request unless the insured agrees to extend the time period. The examination will be conducted by a provider in the same discipline as the treating provider. Upon our request, you must supply medical records and other related information to the examining provider at or before the time of the examination. **Failure to provide the requested medical records at or before the time of the scheduled medical examination may be treated as an unexcused failure to attend an IME.** We will notify you and the insured whether we will authorize further treatment, diagnostic testing or durable medical equipment within three (3) business days following the examination, or the requested treatment, diagnostic testing or durable medical equipment shall be deemed authorized until the results of the IME have been communicated to you. In addition, if a written report is prepared, a copy will be made available upon request.

CONSEQUENCES OF AN INSURED'S UNEXCUSED FAILURE TO ATTEND AN INDEPENDENT MEDICAL EXAMINATION

IT IS IMPORTANT THAT THE INSURED ATTEND ALL SCHEDULED IMEs. YOU SHOULD BE AWARE THAT THE UNEXCUSED FAILURE OF AN INSURED TO ATTEND TWO OR MORE SCHEDULED IMEs MAY RESULT IN NOTIFICATION TO YOU AND THE INSURED THAT NO REIMBURSEMENT WILL BE MADE FOR ALL FURTHER TREATMENT, DIAGNOSTIC TESTING OR DURABLE MEDICAL EQUIPMENT RELATING TO THE DIAGNOSIS CODE(S), AND CORRESPONDING FAMILY OF CODES, CONTAINED IN THE REQUEST OR ATTENDING PROVIDER TREATMENT PLAN FORM THAT NECESSITATED THE SCHEDULING OF THE EXAMINATION, REGARDLESS OF MEDICAL NECESSITY.

7. Please be advised that emergency care treatment or testing does not require our prior authorization. **Decision point review** and **precertification** requirements do not apply within 10 days of the insured event.

Periodic Notice Requirements for Other Injuries

1. If medical treatment is necessary beyond the first 28 days following the accident which does not involve an injury of the neck or back (see paragraph one and **identified injuries**) or services and/or conditions set forth in paragraph three, we must be provided with written support establishing the need for further treatment before reimbursement may be considered. This notification is required every 28 days following the date of the accident for as long as continued treatment is necessary if coverage is sought. We encourage the submission of comprehensive treatment plans for all injuries to avoid periodic reviews when continued treatment is considered medically necessary for an extended period of time. This information must be provided if you or our insured wish to receive reimbursement pursuant to the policy terms.
2. Failure to provide the notification required in paragraph one of this section, may result in a co-payment penalty on eligible medical charges of 25 percent if notice is received 30 or more days after the accident or 50 percent when received 60 or more days after the accident even if services are determined to be medically necessary.

Reconsideration and Appeals Process

If treatment, diagnostic testing or durable medical equipment is not authorized, you may request reconsideration by the Physician making the initial determination or, in his/her absence, another designated Physician by submitting a written request with reasons and supporting documentation within 30 days of receipt of a written denial or modification. Submission of information identical to the initial material submitted in support of the request shall not be accepted as a request for reconsideration. Provided that additional necessary medical information has been submitted, a response to the reconsideration request shall be made within fourteen days. If it is determined that peer review or an Independent Medical Examination is appropriate, this information will be communicated within fourteen days as well. Please note that any treating provider who has accepted an assignment of benefits must complete the Reconsideration and Appeals Process prior to initiating arbitration or litigation.

For disputes on issues other than requests for **decision point review** and **precertification**, any treating provider who has accepted an assignment of benefits must submit a written request for Reconsideration and Appeals specifying the issues in dispute accompanied by supporting documentation at least 21 days prior to initiating arbitration or litigation.

Dispute Resolution Process

Any disputes not resolved in the Reconsideration and Appeals Process may be submitted through the Personal Injury Protection Dispute Resolution process which is governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the National Arbitration Forum (NAF) at 732-271-6100 or toll-free 1-888-881-6231. Information is also available on the NAF's Web site, <http://www.nj.adrforum.com>. Unless emergent relief is sought, failure to utilize the Reconsideration and Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

Assignment of Benefits

If you wish to be paid directly by us for covered services, you must obtain an executed assignment of benefits. This assignment agreement must be furnished to us upon request. As a condition of assignment, you must follow the requirements of this Decision Point Review Plan and shall hold the insured harmless for penalty co-payments imposed by us based on your failure to follow the requirements of our Decision Point Review Plan. Failure to comply with (1) our Decision Point Review Plan Requirements or (2) the requirement to follow the Reconsideration and Appeals Process prior to initiating arbitration or litigation will render any prior assignment of benefits under the policy null and void.

Tests Which Require Decision Point Review

1. Needle electromyography (needle EMG);
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;

3. Electroencephalogram (EEG);
4. Videofluoroscopy;
5. Magnetic resonance imaging (MRI);
6. Computer assisted tomographic studies (CT, CAT Scan);
7. Dynatron/cyber station/cybex;
8. Sonograms/ultrasound;
9. Thermography/Thermograms;
10. Brain mapping; and
11. Any other diagnostic test that is subject to the requirements of a **decision point review** plan by New Jersey law or regulation.

Written Support Required Before Treatment, Testing or Durable Medical Equipment Can Be Considered for Coverage

Written documentation to be supplied to NJM Insurance Group must be legible and clinically supported and establish that a health care provider, prior to selecting, performing or ordering the administration of a treatment, diagnostic testing or durable medical equipment, has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or durable medical equipment;
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 the results of any and all previously performed tests that relate to the injury and which are relevant to the proposed treatment, diagnostic testing or durable medical equipment; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

Completion of the enclosed Health Care Provider Report may be used to satisfy these requirements.

Tests for Which the Law Prohibits Coverage under Any Circumstances

1. Spinal diagnostic ultrasound;
2. Iridology;
3. Reflexology;
4. Surrogate arm mentoring;
5. Surface electromyography (surface EMG);
6. Mandibular tracking and stimulation; and
7. Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Personal Injury Protection coverage.

Pursuant to N.J.A.C. 11:3-4.5(f) and 13:30-8.22(b), we 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 Temporomandibular Joint Disorder (TMJ/D):

1. Mandibular tracking;
2. Surface EMG;
3. Sonography;
4. Doppler ultrasound;
5. Needle EMG;
6. Electroencephalogram;
7. Thermograms/thermographs;
8. Videofluoroscopy; and
9. Reflexology.