

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.state.nj.us/dobi/pipinfo/aicrapg.htm>, or by calling the PIP Claims Representative. If you fail to submit requests for **decision point review** or fail to submit legible clinically supported findings that establish the need for 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** pursuant to 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 are 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, this plan includes a voluntary network for:
 - a. Magnetic Resonance Imagery; and
 - b. Computer Assisted Tomography.

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 attending health care provider. A list of network providers will be available on the Company's Web site at <http://www.NJM.com/Auto/Auto-Preferred-Medical-Providers.asp> or by contacting the appropriate PIP Claims Representative.

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

4. You or our insured must obtain our **precertification** for the following services and/or conditions 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:
 - 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.), including implants and post-operative care/supplies not included in the global fee period. Pursuant to N.J.A.C. 11:3-29.4 et seq., global fee periods and the necessity for co-surgeons and assistant surgeons will be determined based upon the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule and Medicare Claims Manual, which can be found at <http://www.cms.gov>;

- Durable medical equipment (including orthotics and prosthetics) costing greater than \$50, or rental longer than 30 days; A manufacturer's invoice is required for all durable medical equipment costing greater than \$200;
- 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, including but not limited to, quantitative drug testing;
- 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 and DRX;
- Podiatry;
- Audiology;
- Bone Scans;
- Investigational or novel treatment as defined herein;
- Non-emergency transportation services;
- Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;
- Prescriptions, including but not limited to Schedule II, III and IV Controlled Substances, costing more than \$200 for a single fill and/or a 30 day supply;
- Non-medical products, devices, and services not exclusively used for medical purposes;
- Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.

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

5. We encourage you to submit comprehensive treatment plans to avoid periodic reviews when continued treatment is considered medically necessary for an extended period of time. As long as treatment is consistent with the approved plan, additional notification at **decision points** and for treatment, testing or durable medical equipment requiring **precertification** is not required, except as designated in the approval letter. 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 (3) business days after receipt of a request submitted on the appropriate form(s), 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 (3) 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 after 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 attending health care 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. If our insured is non-English speaking, then an English speaking interpreter must accompany him/her to the examination. If unable to attend the scheduled examination, our insured must notify us at least three (3) business days prior to the examination date. **Failure to provide the requested medical records at or before the time of the scheduled medical examination, comply with the interpreter requirement, and/or notify us of an inability to attend a scheduled examination at least three (3) business days prior to the examination date will 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 after 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.
8. Please be advised that reimbursement for medically necessary expenses is subject to the policy deductible, co-payment(s), policy limits, the New Jersey PIP Fee Schedule and the billing and coding guidelines established by the American Medical Association, outlined in the Current Procedural Terminology (CPT) guide, and the provisions of N.J.A.C. 11:3-29.

Please note: Authorized testing, treatment and/or durable medical equipment is approved only for the range of dates noted in the determination letter(s). Medical authorization is based upon medical necessity and is not a guarantee of payment. Medical authorization does not confirm or verify eligibility for coverage, statutory benefits, or payment.

Expired Authorization(s): Any approved treatment, testing and/or durable medical equipment performed/supplied after the authorization period expires (last date in the range of dates indicated in the determination letter), will be considered unauthorized and subject to a penalty co-payment of 50%, even if the services are determined to be medically necessary.

Case Management: A Nurse Case Manager may be assigned to a claim in addition to a PIP Claims Representative.

Hours of Operation: The close of business is 5 p.m. Additionally, please note that "business days" does not include Saturdays, Sundays, legal holidays, or days that the office is closed due to severe weather, mandatory evacuation, or a State of Emergency.

REQUIREMENTS FOR OTHER INJURIES

1. For injuries *other than* the **identified injuries** outlined in paragraph one or the services and/or conditions for treatment, diagnostic testing or durable medical equipment set forth in paragraph four above, we must be provided with written support establishing the need for further treatment before reimbursement may be considered. This documentation is required if medical treatment is necessary beyond the first 28 days following the accident. 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. If a comprehensive treatment plan has not been submitted and approved, notification is required every 28 days following the date of the accident for as long as continued treatment is necessary if coverage is sought. As long as the treatment, diagnostic testing and/or durable medical equipment rendered/supplied is consistent with the approved treatment plan, additional notification every 28 days following the accident is not required. Once a treatment plan has been approved, you or our insured must notify us in writing of the medical necessity of any treatment, diagnostic testing or durable medical equipment that varies from the approved treatment plan before reimbursement will be considered.

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% if notice is received 30 or more days after the accident or 50% when received 60 or more days after the accident even if services are determined to be medically necessary.

APPEALS PROCESS (MANDATORY)

Pre-Service Appeals (Optional)

If you disagree with our determination with respect to requested treatment, diagnostic testing or durable medical equipment that has not yet been provided, you have the option to submit a written request for pre-service appeal with supporting documentation within 30 days of receipt of a written denial or modification. If you choose to file a pre-service appeal, your request must include, as the cover page, a fully completed New Jersey PIP Pre-Service Appeal Form. The New Jersey PIP Pre-Service Appeal Form is available at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm> or may be obtained from the assigned PIP Claims Representative. A submission based on additional medical information that is supplied more than 30 days after the initial request will be considered a new request for **decision point review** or **precertification** and not an appeal. Submission of information identical to the initial material submitted in support of the request shall not be accepted as a valid pre-service appeal. Provided that additional necessary medical information has been submitted, a response to the pre-service appeal shall be made within 14 days. If it is determined that peer review or an Independent Medical Examination is appropriate, this information will be communicated within 14 days as well. Requests for pre-service appeals under this paragraph must be submitted via the facsimile number and/or mailing address provided for the assigned PIP Claims Representative.

Post-Service Appeals

If you do not submit a valid pre-service appeal, a provider of service benefits who has accepted an assignment, or any insured, must submit a written request for post-service appeal for any and all disputes. This includes, but is not limited to, any claims for unpaid medical bills for medical expenses, and services that were not authorized and/or denied in the **decision point review** and **precertification** process. The request must specify the issue(s) contested and provide supporting documentation, including the NJM Explanation of Benefits (EOB), if one was generated. In order to be considered valid, a post-service appeal under this section must be submitted within 180 days of service of the adverse decision and at least 45 days prior to initiating arbitration or litigation. In addition, all requests for post-service appeal must include, as the cover page, a fully completed New Jersey PIP Post-Service Appeal Form and must be faxed to NJM at (609) 963-6075. The New Jersey PIP Post-Service Appeal Form is available at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm> or may be obtained from the assigned PIP Claims Representative. We will neither accept nor respond to post-service appeals that are sent to any other facsimile number or that fail to include a fully completed New Jersey PIP Post-Service Appeal Form. Please note that only requests for post-service appeals under this paragraph will be accepted at this facsimile number. Provided that a valid post-service appeal has been submitted, a response shall be made within 30 days.

As a condition precedent to filing arbitration or litigation, any provider of service benefits that has accepted an assignment of benefits, or any insured, must comply with the Appeals Process at least 45 days prior to initiating arbitration or litigation. If the insured or provider of service benefits retains counsel to represent them during the Appeals Process, they do so strictly at their own expense. NJM will not reimburse for counsel fees or any other costs, regardless of the outcome of the appeal.

DISPUTE RESOLUTION PROCESS

Any disputes not resolved in the Appeals Process may be submitted through the Personal Injury Protection Dispute Resolution process 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 Forthright at (732) 271-6100 or toll-free at (888) 881-6231. Information is also available on Forthright's Web site, <http://www.nj-no-fault.com>. We retain the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. Unless emergent relief is sought, failure to utilize the Appeals Process and submit a valid appeal at least 45 days prior to filing arbitration or litigation will invalidate an assignment of benefits.

Per Forthright Rule 7. Demand for Arbitration, "[T]he demand shall also be simultaneously served upon all named parties by electronic service as may be permitted by the party to be served, certified mail return receipt requested or by personal service. The demand shall be served at the address of the party or, in the case of an insurer, at the address for service designated pursuant to N.J.A.C. 11:3-5.6(a)."

Demands shall be served upon NJM via facsimile to (609) 963-6127 or email to PIPLitigation@njm.com.

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 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, (2) the insured's duties under the automobile insurance policy or (3) the requirement to comply with the Appeals Process and submit a valid appeal at least 45 days prior to initiating arbitration or litigation will render any prior assignment of benefits under the policy null and void.

Should any action be filed seeking relief under the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1 et seq., N.J.S.A. 39:6A-13(g) or any cause of action alleging fraud or similar misconduct, the insured and/or the provider must agree to put any arbitration proceedings in abeyance until the legal action is resolved.

TESTS WHICH REQUIRE DECISION POINT REVIEW

1. 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/cybox;
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.

Pursuant to N.J.A.C. 11:3-4 et seq., NJM will provide reimbursement for the tests set forth in Numbers (1) and (2) only when the test results and reports meet the **standard professional treatment protocols** of the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) as outlined in the Position Statements at <http://www.aanem.org>, even if the tests were authorized through the **decision point review** or **precertification** process.

WRITTEN SUPPORT REQUIRED BEFORE TREATMENT, TESTING OR DURABLE MEDICAL EQUIPMENT CAN BE CONSIDERED FOR COVERAGE

Pursuant to N.J.A.C. 11:3-4.7(d), all attending health care providers must use the Attending Provider Treatment Plan (AFTP) form to submit **decision point review** and **precertification** requests. No other form will be accepted. A copy of the AFTP form is available at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm>,

<http://www.NJM.com/pdf/AC-PIP17w.pdf> or by contacting the assigned PIP Claims Representative.

A properly submitted APTP form must be completed in its entirety and must include the injured party's full name, date of birth, the claim number, the date of accident, diagnoses/ICD codes(s), each CPT code requested, including frequency, duration/treatment period and the signature of the requesting physician. Requests that are not submitted on this form will be denied for insufficient information and a completed form will be requested and required.

Requests for additional pain management treatment must comply with items 1-4 below and be consistent with **standard professional treatment protocols** as defined by N.J.A.C. 11:3-4.2. Results of previously completed pain management treatment must include, but not be limited to, an objective assessment of patient's response to completed treatment. Failure to include such an objective assessment will result in a denial of authorization for additional treatment.

In addition, we require supplemental information for all requests for surgical procedures (CPTs 10000-69999), including the name of the facility where services will be performed, the proposed surgery date, the need for and names of co-surgeons, assistant surgeons, physician assistants and/or RNFAs as supported by CMS guidelines, anticipated post-operative services and care not included in the global fee, such as therapy, diagnostic testing and/or durable medical equipment. This information may be submitted on the Surgery Precertification Request NJ No-Fault Claims form, which is attached for your convenience and is also available at <http://www.NJM.com/pdf/AC-204.pdf> or by contacting the assigned PIP Claims Representative. Requests for surgeries that do not include the necessary information will be denied as deficient until the additional information required is supplied.

Written documentation to be supplied to NJM Insurance Group must be legible, clinically supported, and establish that an attending 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.

Please note: An APTP form may not be submitted by and will not be accepted from a provider of service benefits who did not personally physically examine the patient. This includes, but is not limited to, DME suppliers, imaging facilities, Ambulatory Surgery Centers, and pharmacies. An APTP form must be submitted by the attending health care provider ordering the requested treatment, diagnostic testing or durable medical equipment.

COVERAGE RESTRICTIONS

The law prohibits reimbursement under any circumstances for the diagnostic testing itemized at N.J.A.C. 11:3-4.5.

We will not authorize or reimburse services when primarily provided for the convenience of the injured party and/or provider, including, but not limited to, the following:

- Investigational or novel treatment when the medical procedure, diagnostic test, durable medical equipment, drug, or other service fails to meet any one of these criteria: (1) the technology, if any, must be approved by the appropriate federal agency; (2) there is sufficient evidence in peer-reviewed scientific literature to assess the effectiveness of the treatment; (3) the treatment results in measurable improvement in the health outcome and the therapeutic benefits outweigh the risks; (4) the treatment is as safe and effective as established **standard professional treatment protocols**; and (5) the treatment demonstrates effectiveness when applied outside of the investigative research setting.
- Prescription medications, drugs, and/or biologicals that are not approved by the USFDA.
- Compound prescription medications, drugs, and/or biologicals that, as compounded, are not approved by the USFDA. This includes, but is not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.