PRE-CERTIFICATION AND DECISION POINT REVIEW PLAN

The New Jersey Department of Banking and Insurance has published standard courses of treatment, identified as Care Paths, for soft tissue injuries of the neck and back, collectively referred to as Identified Injuries, pursuant to N.J.A.C. 11:3-4. N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests.

An Eligible Injured Person (EIP) is a person seeking Personal Injury Protection benefits (PIP) in accordance with N.J.S.A. 39:6A from an automobile insurance policy for which Active Care is the PIP vendor, used by the insurer for utilization management. "Utilization Management" means a system for administering some or all of an insurer's decision point review plan, including, but not limited to, receiving and responding to Decision Point Review and Pre-Certification requests, making determinations of medical necessity, scheduling and performing independent medical examinations, bill review and handling of provider appeals.

This Pre-Certification and Decision Point Review plan sets out rights and duties of persons or entities seeking PIP benefits.

Throughout this document, Decision Point Review means the timely review of treatment of certain identified injuries, at the junctures in the treatment of those identified injuries, where a decision must be made about continuation or choice of further treatment. Decision Point also refers to a determination to administer one or more diagnostic tests authorized by the Department of Banking and Insurance. Our Decision Point Review and Pre-Certification Plan is specifically described below.

Decision Point Review Plan

Pursuant to the changes made as a result of the Automobile Insurance Cost Reduction Act of 1998, the New Jersey Department of Banking and Insurance has published standard courses of treatment, or Care Paths, to monitor the treatment rendered when an EIP is diagnosed with one or more of the Identified Injuries. The Care Paths provide that treatments be evaluated at certain intervals called Decision Points.

In addition, the determination to administer certain diagnostic tests also involves a Decision Point, regardless of the diagnosis. At these Decision Points, before the treatment in question is rendered, we will require the health care provider to submit documentation regarding the injuries, treatments and results of diagnostic testing. Also, we may request that a health care provider of our choice examine the EIP. Failure to request Decision Point Review when required will result in a penalty co-payment. All services must be medically necessary, clinically supported by information provided by the health care provider, and related to the injuries sustained in the accident in order to be reimbursed.

For a complete copy of the Care Paths and a list of the identified injuries, please visit the web site of The Department of Banking and Insurance. www.nj.gov/dobi/aicrapg.htm.

The following diagnostic testing always requires a Decision Point Review:

1. Needle Electromyography (EMG);
2. Somasensory Evoked Potential (SSEP),
3. Visual Evoked Potential (VEP),
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potential (BEP)
6. Nerve Conduction Velocity(NCV), or H-reflex Study
7. Electroencephalogram (EEG)
8. Videofluroscopy
9. Magnetic Resonance Imaging (MRI)

10. Computer Assisted Tomographic Studies (CT, CAT Scans)
11. Dynatron/Cybex Station/Cybex
12. Sonograms/Ultrasounds
13. Thermography/Thermograms
14. Brain mapping, when done in conjunction with appropriate neurodiagnostics.
15. Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation.

PIP benefits will not pay for diagnostic testing that has no clinical value or is ineligible under the rules, regulations or laws of New Jersey, or as determined by the NJ Department of Banking and Insurance as being not reimbursable.

Personal Injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, under any circumstances, pursuant to N.J.A.C. 11:3-4:

1. Spinal diagnostic ultrasound
2. Iridology
3. Reflexology
4. Surrogate arm mentoring
5. Surface electromyogrophy (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 PIP coverage.

Mandatory Pre-Certification Plan

If the EIP has been diagnosed with an injury that is not an Identified Injury, the health care provider must contact us for prior authorization of the treatments and services listed below. No Pre-Certification requirements shall apply for the first ten (10) days of the insured event. Pre-Certification shall be based exclusively on medical necessity and shall not encourage under or over utilization of the treatment service or test.

For treatment, diagnostic testing, durable medical equipment or other medical expenses not included in the Care Paths or subject to Decision Point Review, the EIP or the health care provider is required to obtain our pre-certification for the services and/or conditions listed below. If the EIP or the health care provider fails to pre-certify such services, or fails to provide clinically supported findings that support the medical necessity of the treatment, services and/or conditions, diagnostic tests, other medical expenses or durable medical equipment requested, payment of bills will be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary.

{Please review your insurance policy and the Decision Point Review Plan of the insurer from whom PIP benefits are being sought.}

The following treatments, services and/or conditions, goods and non-medical expenses {may} require Pre-Certification:

1. Physical, occupational, speech, cognitive or other restorative therapy, or other body part manipulation, except that provided for identified injuries in accordance with a Decision Point Review.
2. Acupuncture
3. Nerve blocks
4. Manipulation under anesthesia
5. Anesthesia when performed in conjunction with invasive techniques
6. Radiofrequency ablation/Rhyzotomy
7. Narcotics, when prescribed for more than three months
8. Biofeedback

9. Implantation of spinal simulators or spinal pumps
10. Trigger point injections
11. PENS (Percutaneous Electrical Nerve Stimulation)
12. TENS units transcutaneous electrical nerve stimulation) and supplies
13. Non-emergency transportation services by ambulance or ambulette
14. Non-emergency surgical procedures performed in a hospital, freestanding surgical center, office, etc., and any provider services associated with the surgical procedure
15. Non-emergency inpatient and outpatient hospital care including the facility where the services will be rendered and any provider services associated with these services and/or care
16. Extended care rehabilitation facilities
17. Outpatient psychological, psychiatric testing and/or services
18. Durable medical equipment including orthotics and prosthetics with a cost or monthly rental in excess of $50.00
19. Prescriptions costing more than $50.00
20. Transportation Services costing more than $50.00
21. Home health care
22. All pain management services except as provided for identified injuries in accordance with Decision Point Review
23. Non emergency dental restoration
24. Skilled nursing care
25. Discograms
26. Infusion therapy
27. Temperature gradient studies
28. Work hardening
29. Carpal Tunnel Syndrome
30. Audiology
31. Bone Scans
32. Non-Emergency Dental Restoration
33. Any procedure that uses an unspecified CPT, CT, DSM IV, HCPSC codes
34. Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a cost of $50.00 and/or monthly rental greater than 30 days, including but not limited to:

    a. Vehicles
    b. Modifications to vehicles
    c. Durable goods
    d. Furnishings
    e. Improvements or modifications to real or personal property
    f. Fixtures
    g. Recreational activities and trips
    h. Leisure activities and trips
    i. Spa/gym memberships

General Provisions applicable to both Decision Point Review and Pre-Certification

1. Any treatment to which Decision Point Review or Pre-Certification has been applied shall also be subject to all terms and conditions contained within the insurance policy.
2. Neither Decision Point Review nor Pre-Certification will apply to the first 10 days of care immediately after an accident or during emergency care. Treatment received during those first 10 days will be subject to utilization review. However, if treatment, testing or services received at any time, including the first 10 days after an accident is not medically necessary, appropriate and does not meet nationally recognized guidelines or protocols for such services, New Jersey Automobile Insurers may not be responsible to pay for them.

3. This Plan will not limit access to medically necessary care required. Medically necessary treatment is described as medical treatment or diagnostic test consistent with the clinically supported symptoms, diagnosis or indications of the injured persons and the treatment is the most appropriate level of service that is in accordance with standards of good practice and standard profession protocols. Standard professional treatment protocols are defined as treatment that meets evidence-based clinical guidelines/practice/treatment, published in peer-review journals.
4. This Plan will not allow for over-utilization of care, nor will it allow for the care that is solely for the convenience of the EIP or the health care provider. Pursuant to N.J.A.C. 11:3-4. 5 the plan will not allow for unnecessary testing or treatment.
5. Treatment must be Clinically Supported. Clinically supported means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

    a. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
    b. Physically examined the patient including making an assessment of any current and /or historical subjective complaints, observations, objective findings, neurological indications, and physical tests;
    c. 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
    d. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

6. Active Care will follow procedures for the prompt review, not to exceed three business days, following our receipt of Decision Point Review/Pre-Certification requests by a health care provider as established by the Department of Banking and Insurance and this Decision Point Review and Pre-Certification plan. All determinations on treatments or tests shall be based on medical necessity and shall not encourage over or under utilization of benefits. Denials of Decision Point Review and Pre-Certification requests on the basis of medical necessity shall be based upon the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be based upon the determination of a dentist;
7. The EIP and the health care provider are strongly urged to formulate and submit a Comprehensive Treatment Plan at the beginning of treatment, regardless of whether the injury requires Decision Point Review or Pre-Certification. Once the Medical Director approves a Comprehensive Treatment Plan, there is no need to seek further approval for those services specifically described in the treatment plan.

Notification under Decision Point Review / Pre-Certification:

1. Immediately after an insured is involved in a covered accident, the insured must provide notice to us the possibility that he/she has sustained a bodily injury as a vehicle accident. The insured must provide us notice, at the latest within ten (10) days after the covered accident.

    However, in the event notice is not received within 21 days of the commencement of treatment, we will reduce payments in accordance with the law or, under certain circumstances, deny the claim in accordance with NJAC 11:3-25. If notice of the accident is not received by us until 30 or more days after the accident, we reserve our right to require a co-payment of at most 25%. In the event we do not receive notice until 60 or more days after the accident, we reserve our right to require a co-payment of at most 50%.

2. The insured must provide us "with proof that the treatment he/she has already received or shall receive in the future is "clinically supported." The insured must also provide his/her treating physician's diagnosis and development of his/her treatment. Specifically the insured must provide us with:

a. The date of the accident
b. The dates of any previous treatment
c. His/her clinical symptoms;
d. The diagnostic tests performed and their results
e. Any recommended test; and
f. Any pre-existing conditions

3. Notices pursuant to the terms, conditions, provisions, exclusions and limitation of the insurance policy and this plan shall be made to: The Greenwich Insurance Company, at its Claims Office Located at: 505 Eagleview Blvd. Exton, PA 19341 Phone: (610)968-2896 Fax: (610)458-6653

Submission Requirements under Decision Point Review/Pre-Certification

Active Care requires the health care provider to submit documentation with the nature and extent of the EIP's injuries, type and duration of treatment and diagnostic tests to be performed, and/or durable medical equipment requested in order to approve treatment. Upon receipt of a properly submitted Attending Provider Treatment Plan (APTP) for medically necessary and clinically supported treatment, Active Care will approve, modify or non-certify the request. Active Care may also request additional information, if the additional information is necessary to make a decision or may request the EIP attend an Independent Consultative Examination to determine medical necessity.

In order for a request to be considered and reviewed by Active Care, it must contain the following:

1. A fully completed, legible and signed Attending Provider Treatment Form
2. Legible, current notes from the ordering physician to support the request for treatment.
3. All supporting documentation and test results.

If we make a request for additional information, the requested information must be submitted by the health care provider within ten (10) days. The additional information must be legible and clinically support the requested services. Failure to provide any requested medically necessary information may result in an additional penalty co-payment of 50% of eligible charges. Clinically supported information must:

1. Include the date of accident.
2. Be based on actual, current examination, a complete history of all complaints, clinical symptoms, dates and types of previous treatments and observations.
3. Report objective findings, diagnosis (ICD-9 codes) and results of physical examinations and tests performed.
4. Indicate that the health care provider has considered any previous tests and examinations performed, and consider any and all other conditions the EIP may have had prior to the accident, and render a diagnosis as it relates to the accident.

A Decision Point Review/Pre-Certification request must be submitted on a properly submitted Attending Provider Treatment Plan form pursuant to N.J.A.C 11:3-4.7(d). This form can be located at: http://www.state.nj.us/dobi/orders/treatmentform.pdf.

All requests for Decision Point Review or Pre-Certification must be submitted directly to Active Care. They must be submitted by fax 973-257-2287.

Active Care's regular business hours are 7:30 AM – 4:00 PM EST/EDT Monday – Friday. Any requests received on a weekend or legal holiday or after our regular business hours will be considered received on the next business day.

Who may submit a Decision Point Review/Pre-Certification Request

The Attending Provider Treatment Plan (APTP) form may be completed by the healthcare provider and submitted to Active Care for review, subject to the conditions and limitations set forth below. A health care provider is a person licensed or certified to perform health care treatment or services compensable as medical expenses in accordance with New Jersey law and regulation.

1. Physical Therapists may submit APTP forms with specific CPT codes to be used for treatment purposes; however, in order for this request to be considered complete, it must include the ordering physician's prescription, current and legible notes from the ordering physician indicating a need for physical therapy, which body part is to be treated and the response to previous treatment. A legible physical therapy evaluation must also be submitted.
2. Suppliers of Durable Medical Equipment (DME), transportation services, ambulatory surgical centers, and suppliers of prescription drugs may not submit APTP's.
3. Attending Provider Treatment Plans for diagnostic testing may only be submitted by the prescribing Health Care Provider.

It is the responsibility of the health care provider to advise Active Care of any change in condition or need for services.

"Day or Days"

"Days" mean calendar days unless specifically designated as business days.

A calendar and business day both end at the time of the close of business hours.

In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time, designated as a calendar day, is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

Comprehensive Treatment Plans under Decision Point Review or Pre-Certification

A Comprehensive Treatment Plan may be submitted by you or your health care provider. This Comprehensive Treatment Plan will outline treatment, diagnostics, and procedures to be completed in a specified period of time. Once a Comprehensive Treatment Plan is approved or modified by a medical director, no further Decision Point Review or Pre-Certification requests will need to be submitted unless changes need to be made.
If there is no Comprehensive Treatment Plan submitted, then Decision Point Review/Pre-Certification is required to avoid co-payment penalties.

Independent Consultative Opinion Examination under Decision Point Review or Pre-Certification

Active Care or the Insurance Carrier from which PIP benefits are sought may request that the EIP submit to an Independent Consultative Examination (ICE). This examination will be with a health care provider in the same discipline as the treating health care provider, and will take place at a location reasonably convenient to the EIP. Active Care will schedule the examination within seven (7) days, unless the injured person agrees to extend the time period. Active Care will notify the EIP in writing of the appointment information. Medically necessary treatment, during this time, will not be interrupted. However treatment will be subject to utilization review. The treating health care provider will be notified of the outcome of the exam within three (3) business days. Upon receipt of the written report from the examining physician, a letter will be sent to the EIP and treating provider

with an explanation of treatment needs/denials and rationale for same.
A copy of examining physician report is available from the insurance carrier upon request.

The EIP must cooperate with us in scheduling and attending the examination.

You are required to provide the independent examining physician with all medical records and diagnostic testing including results and films at the time of the examination. Failure to provide medical records and diagnostic testing including results and films will result in an unexcused failure to attend the examination.

If you must reschedule your appointment, you must call the First MCO IME department at 973-257-5230 three business days in advance of the appointment. Failure to cancel the appointment timely will result in an unexcused failure to attend the examination. Any cancellation of appointment that is done later than 3 business days after the receipt of the appointment notice will result in and unexcused failure to attend.

If you do not speak English, you will be required to provide your own interpreter. Please have a reliable source attend the appointment with you to translate. Failure to provide translator at time of appointment will result in an unexcused failure to attend the examination.

Transportation will not be provided. Please make necessary arrangements to attend the scheduled appointment. If transportation is an issue, contact your insurance carrier to discuss any available transportation services. Failure to attend the appointment due to lack of sufficient transportation will be considered and unexcused failure to attend the examination.

There may be times when there are waits at doctors' offices. Leaving a scheduled appointment due to wait time will be considered an unexcused failure to attend the examination.

Examples of an unexcused failure to attend the examination include but are not limited to any one of the following:

1. Failure to provide medical records and diagnostic testing including results and films at the time of the examination.
2. Failure to provide adequate proof of identification.
3. Failure to be accompanied by an English speaking translator if you do not speak English.
4. Failure to arrange for transportation.
5. Failure to cancel an examination with three business days of the exam.
6. Failure to reschedule the exam within three days of the receipt of notification of exam.
7. Failure to attend exam due to wait time.
8. Failure to present for any examination due to any reason

More than one unexcused failure to attend a scheduled physical examination may result in denial of reimbursement for further treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form due to failure to comply with the plan.

Penalty under Decision Point Review or Pre-Certification

Failure to request Decision Point Review or Pre-Certification, where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested, will result in an additional co-payment of 50% of eligible charges 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. This is in addition to any deductible or co-payment applicable to the loss.

Voluntary Networks

Active Care, through our plan administrator, has Voluntary Networks for the following:

1. Magnetic Resonance Imagery – The Active Care Network
2. Computer Assisted Tomography – The Active Care Network
3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except when performed by the treating physician in conjunction with a needle EMG – The Active Care Network
4. Durable medical equipment with a cost or monthly rental in excess of $50.00 – The Active Care Network
5. Prescription drugs – The Active Care Network
6. Services, equipment or accommodations provided by an ambulatory surgery facility.

Use of the voluntary network is strictly voluntary. However, if you do not utilize the voluntary Network for the items listed above, an additional 30% co-payment will apply for each service or test. For a list of voluntary network providers please contact The Active Care case manager at 800-752-5158.

Preferred Provider Organization (PPO)

Active Care also has a preferred provider organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. Use of the preferred provider organization is strictly voluntary. Active Care has preferred providers through the state of New Jersey. Contact your Active Care nurse case manager for further information regarding providers in your area.

Internal Appeals Process

The internal appeals process shall permit a health care provider who has been assigned benefits to appeal any adverse decision. An “adverse decision” is any determination by the insurer with which the provider does not agree.

Internal appeals will be divided into two types of appeals – Treatment Appeals and Administrative Appeals.

1. Treatment Appeals refer to any adverse decisions regarding the medical necessity of future treatment or testing that was requested by the treating provider on a properly completed Decision Point Review/Precertification request.
2. Administrative Appeals refer to all other adverse decision.

Treatment Appeals

The health care provider may request Active Care review any adverse decision regarding medical necessity of future treatment. The request for appeal must be in writing and submitted to Active Care within fourteen (14) days of our written notification. Attached to the request, you must provide any additional information you wish to be considered. Appeals should be submitted to Active Care via fax at 973-257-2287 or by mail to PO Box 870, Monroe, NY 10949.

Once a properly submitted written appeal is received, Active Care will send the appeal to a medical director for review, reverse the medical director’s decision and authorize, or schedule an Independent Consultative

Examination (ICE). An appeal of an ICE will only be considered if additional information is submitted. If additional information is submitted, this information will be forwarded to the ICE provider for review. A decision to stand by the ICE, modify the decision or approve the requested treatment will be made.

Acknowledgment of Receipt of Appeal will be sent within three (3) business days of receipt. Notification of decision will be faxed to the provider within ten (10) business days after acknowledgment of receipt date. Upon receipt of the written report from the reviewing physician, formal letters will be mailed to the ordering provider and the EIP/attorney.

Administrative Appeals

Administrative Appeals must be submitted within 180 days of the adverse decision that is the basis for the appeal. The appeal must be submitted for review with supporting documentation via fax to Active Care billing department at 973-257-2281 or mailed to PO Box 870, Monroe, NY 10949. An acknowledgment of receipt of appeal will be sent within five (5) business days. An outcome decision will be sent to the provider in writing within thirty (30) business days after acknowledgment of receipt date.

All internal appeals (1 and 2) must be submitted at least thirty (30) days prior to filing a demand for Arbitration.

In the event we do not resolve the dispute, arbitration may be filed. Arbitration shall be in accordance with the regulations of the Department of Banking and Insurance and filed with the appropriate Dispute Resolution Organization.

Assignment of Benefits

Assignment of a named insured or eligible injured person's rights and duties under the policy of insurance is prohibited except to a provider of service benefits who agrees to:

1) Fully comply with the Decision Point Review Plan, including Pre-Certification requirements,
2) Comply with the terms and conditions of the insurance policy
3) Provide complete and legible medical records and other pertinent information when requested by Active Care.
4) Utilize the internal appeals process which shall be a condition precedent to the filing of a demand for alternative dispute resolution for any issue related to bill payment, bill processing, Decision Point Review request or Pre-Certification requests.
5) Submit disputes to alternative dispute resolution pursuant to N.J.A.C. 11:3
6) Consent to the consolidation of all pending Arbitration involving the same person, accident, or claim number.

Failure by the provider of service benefits to comply with all of the foregoing requirement will render any prior assignment of benefits under the insurance companies policy null and void. Should the provider accept direct payment of benefits, the provider is required to hold harmless the insured and the insurance carrier for any reduction of payment for services caused by the provider's failure to comply with the terms of the insurance carrier's policy.