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April 18, 2017

PIP ALERT

ATTN: **Medical Providers/Billing Companies**
From: **Joseph A. Massood, Esq.**
Re: **New Appeals Process Post Service Appeal Time Frames**

The new appeals process became effective on April 17, 2017. Despite the fact that the Administrative Regulation only requires post-service appeals to be filed 45 days prior to initiating arbitration, DOBI has permitted insurance companies to create their own time frames for filing post-service appeals.

A. PLIGA

- **PLIGA requires post-service appeals to be submitted to the carrier within 60 days from the date of the denial – EXHIBIT 1.**

- **PLIGA is also requiring the medical providers to disclose the name of the anesthesiologist in their pre-certification request and has a separate form for surgery pre-certification requests – EXHIBIT 2.**

B. Metlife

- **Metlife's DPRP requires post-service appeals to be submitted to the carrier within 90 days from the date of the denial –EXHIBIT 3.**

C. NJM

- **NJM requires post-service appeals to be submitted to the carrier within 180 days from the date of the denial – EXHIBIT 4.**

D. Geico

- **Geico requires post-service appeals to be submitted to the carrier within 90 days from the date of the denial –EXHIBIT 5.**

Disclaimer: The statements listed above are for informational purposes only and are <u>not</u> to be used as legal advice. Should you have further questions, please contact the undersigned directly.

E. Plymouth Rock

- **Plymouth Rock has a supplemental surgical pre-certification request – EXHIBIT 6, which requires disclosure of co-surgeons, assistants, and post-operative physical therapy.**

We are in the process of compiling a comprehensive updated appeals pamphlet which outlines each insurance company's specific time frames. Kindly send our firm revised DPRPs when you receive them.

EXHIBIT 1

NEW JERSEY PROPERTY-LIABILITY INSURANCE GUARANTY ASSOCIATION
DECISION POINT REVIEW PLAN INCLUSIVE OF PRECERTIFICATION REQUIREMENTS

SUMMARY OF CHANGES - EFFECTIVE APRIL 17, 2017

1. Anesthesiologists are required to be identified for surgical procedures. All requests for surgical procedures (CPT codes 10000-69999) require supplemental information 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, **anesthesiologists**, physician assistants and/or registered nurse first assistants as supported by the Centers for Medicare and Medicaid Services ("CMS") guidelines, anticipated post-operative services and care not included in the global fee period, including but not limited to, therapy, diagnostic testing and/or DME.

2. Mandatory precertification applies to non-emergency drug screening and/or drug testing, including but not limited to any technical analysis of urine, hair, blood, breath, sweat, saliva or other biological specimen used to detect the presence or absence of specified drugs or their metabolites, controlled substances, alcohol or drugs prohibited by law.

3. The link to DOBI's interpretation of the auto medical fee schedule can be viewed at the DOBI's website. A link to the DOBI's website is also accessible from the NJPLIGA website, www.njguaranty.org. The current NCCI edits can be obtained from the Center for Medicare and Medicaid Services website. A link to the Center for Medicare and Medicaid Services website is also accessible from the NJPLIGA website, www.njguaranty.org.

4. The pre and post service appeal timeframes have been amended in line with the newly adopted amendments to medical protocols www.nj.gov/dobi/proposed/ad161017.pdf:

    a. Pre-Service Appeals shall be submitted no later than thirty (30) calendar days after the treating health care provider has received notice of the adverse decision that is the basis for the appeal. Pre-Service Appeals may not be submitted as administrative appeals. Provided that additional necessary medical information is submitted with the Pre-Service Appeal, NJPLIGA will render a decision within fourteen (14) calendar days of receipt of the pre-service appeal form and all necessary supporting documentation, unless it is determined that a peer review or an IME is appropriate.

    b. The treating health care provider will be notified within fourteen (14) calendar days if a peer review or IME is required.

    c. In order to be considered valid, all Post-Service Appeals must be submitted within sixty (60) calendar days of the adverse decision and at least forty five (45) calendar days prior to initiating arbitration or litigation.

    d. NJPLIGA will render a decision within thirty (30) calendar days from the date of the appeal.

NEW JERSEY PROPERTY-LIABILITY INSURANCE GUARANTY ASSOCIATION
DECISION POINT REVIEW PLAN INCLUSIVE OF PRECERTIFICATION REQUIREMENTS

Please read this information carefully and share it with your health care providers.

This notice informs claimant and/or claimant's health care provider pursuant to a Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements of his/her rights and obligations under the Decision Point Review/Precertification Plan ("DPR Plan") utilized by the New Jersey Property-Liability Insurance Guaranty Association ("NJPLIGA"), in its capacity as the administrator of the claims of insolvent insurance companies and the Unsatisfied Claim and Judgment Fund ("UCJF") under the UCJF Law, N.J.S.A. 39:6-60 et seq.

The waiver by NJPLIGA of any provision contained in this DPR Plan shall not be deemed to constitute a waiver of any other provisions contained herein. The failure of NJPLIGA to enforce any of the provisions contained in this DPR Plan shall not be construed as a waiver of the right of NJPLIGA thereafter to enforce any such provisions.

The NJPLIGA DPR Plan and all applicable forms are available on the NJPLIGA website, www.njguaranty.org. Copies may also be obtained by contacting NJPLIGA at (908) 382-7100.

DECISION POINT REVIEW

Pursuant to N.J.A.C. 11:3-4.1 et seq., the New Jersey Department of Banking and Insurance ("DOBI") has published standard courses of treatment, identified as **Care Paths**, for soft tissue injuries of neck and back, collectively referred to as **Identified Injuries**. N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests. All services must be medically necessary, clinically supported by information provided by claimant's treating health care provider and related to the injuries sustained in the accident.

The Care Paths provide for the evaluation of treatment at certain intervals called **Decision Points**. At Decision Points, claimant or claimant's treating health care provider must provide NJPLIGA information about further treatment the health care provider intends to perform. This is called **Decision Point Review**. Precertification is the pre-approval of medical procedures, treatments, United States Food and Drug Administration ("USFDA") approved prescription medication, diagnostic tests or other services, non-medical expenses and durable medical equipment ("DME") that are not subject to Decision Point Review. NJPLIGA 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 DOBI as not being reimbursable. Information regarding Decision Point Review and the Care Paths is available on the DOBI's website at www.nj.gov/dobi/aicrapg.htm.

Pursuant to N.J.A.C. 11:3-4.7, treatment obtained in an emergency situation and/or within ten (10) days[1] of the insured event, is not subject to Decision Point Review/Precertification requirements. This provision shall not be construed to require reimbursement of tests and/or treatment that are not medically necessary, N.J.A.C. 11:3-4.7(b). If claimant's treating health care provider fails to request Decision Point Review/Precertification when required or fails to provide clinical findings that support the treatment, testing, USFDA approved prescription medication or DME, a co-payment of fifty percent (50%) will apply even if the services are determined to be medically necessary and causally related to the accident.

NJPLIGA has designated a Medical Director to ensure Decision Point Review/Precertification requests are based upon medical necessity in accordance with N.J.A.C. 11:3-4.1 et seq. NJPLIGA will provide Decision Point Review, Precertification and other medical management services as permitted under New Jersey law, rules and regulations.

NJPLIGA will be available from 8:00 a.m. to 4:30 p.m., Monday through Friday, to respond to provider Decision Point Review and Precertification requests and inquiries by phone (908) 382-7100 or fax (908) 382-7157. Voicemail will be activated for messages received on weekends, holidays and before or after hours and will be handled on the next business[2] day.

DIAGNOSTIC TESTING

The following diagnostic tests are subject to Decision Point Review:

- Brain mapping
- Brain audio evoked potentials ("BAEP")
- Brain evoked potentials ("BEP")
- Computer assisted tomograms ("CT", "CAT" scan)

[1] "Days" is defined as calendar days unless specifically designated as "business days" in this DPR Plan. A calendar day ends at the close of business hours. The day a request or any other communication is received by NJPLIGA is not counted when calculating the number of days.
[2] "Business day" is defined as Monday through Friday, 8:00 a.m. to 4:30 p.m., not including Saturdays, Sundays, State or Federal holidays or days that the office is closed due to severe weather, mandatory evacuation or a State of Emergency. The day a request or any other communication is received by NJPLIGA is not counted when calculating the number of days.

- Dynatron/cybex station/cybex studies
- Video fluoroscopy
- H-reflex studies
- Sonogram/ultrasound
- Needle electromyography (needle "EMG")
- Nerve conduction velocity ("NCV")
- Somatosensory evoked potential ("SSEP")
- Magnetic resonance imaging ("MRI")
- Electroencephalogram ("EEG")
- Visual evoked potential ("VEP")
- Thermogram/thermography
- Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation

Pursuant to N.J.A.C. 11:3-4.5, the following tests are prohibited under any circumstances:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation
- X-ray digitization and/or computer assisted radiographic mensuration
- 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), NJPLIGA will 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):

- Mandibular tracking
- Surface EMG
- Sonography
- Doppler ultrasound
- Needle EMG
- Electroencephalogram ("EEG")
- Thermograms/thermographs
- Videofluoroscopy
- Reflexology

NJPLIGA will also not provide reimbursement for the following:

- Laboratory testing services from any entity that is not certified by the Department of Health and Human Services ("HHS").
- Prescription medications, drugs and biologicals that are not approved by the USFDA.
- Compound prescription medications, drugs and/or biologicals that, as compounded, are not approved by the USFDA, including but not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.
    - NJPLIGA has no obligation to reimburse for specific CPT/HCPC codes, even if those codes are pre-certified through a Decision Point Review or Precertification request as being medically necessary and causally related to the accident, if the DOBI has adopted payment adjudication methodologies in the NJ PIP regulations that consider those charges not to be reimbursable. These payment adjudication methodologies include, but are not limited to, the NCCI edits and other Medicare guidelines. The link to DOBI's interpretation of the auto medical fee schedule can be viewed at the DOBI's website. A link to the DOBI's website is also accessible from the NJPLIGA website, www.njguaranty.org. The current NCCI edits can be obtained from the Center for Medicare and Medicaid Services website. A link to the Center for Medicare and Medicaid Services website is also accessible from the NJPLIGA website, www.njguaranty.org.

NOTIFICATION REQUIREMENTS

Upon receiving notification of a claim, NJPLIGA will investigate the matter and take the necessary steps to protect our mutual interests with the understanding that NJPLIGA does so under a complete reservation of rights. NJPLIGA reserves all

rights and defenses available to it pursuant to applicable statutes, rules, regulations and this DPR Plan (collectively "NJPLIGA's Rights"). Any action that NJPLIGA may take in the investigation or defense of a claim is not to be construed as a waiver of NJPLIGA's Rights. NJPLIGA reserves the right to alter or amend its determinations should additional information be provided to NJPLIGA as part of its investigation or in the course of handling a particular claim.

Failure to timely provide NJPLIGA with information as part of its investigation prejudices NJPLIGA's ability to timely complete its investigation and manage the medical care of those claims that satisfy eligibility requirements. Any person who knowingly files a statement of claim containing any false or misleading information or intentionally omits information material to the claim is subject to criminal and civil penalties.

Upon notification of a covered injury, NJPLIGA will promptly provide the claimant with the following information: a letter summarizing the DPR Plan, Decision Point Review/Precertification procedures, the necessary no-fault forms, an introductory letter to the treating health care provider advising of the DPR Plan requirements and a Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements form. Information will be provided on how to contact NJPLIGA. The circumstances under which a co-payment penalty may apply will be explained. Periodic communication with the claimant and the provider will occur as appropriate.

Decision Point Review will be conducted in accordance with the Care Path Treatment Protocols set forth in N.J.A.C. 11:3-4.1 et seq. and the standards for diagnostic tests set forth in N.J.A.C. 11:3-4.5. 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. At each Decision Point, the treating health care provider is required to consult with NJPLIGA for Decision Point Review.

DECISION POINT REVIEW APPLIES TO THE FOLLOWING:

1. All treatment of accidental injury to the spine and back for ICD Codes specified in the Care Paths in N.J.A.C. 11:3-4.1 et seq.
2. All diagnostic tests identified in N.J.A.C. 11:3-4.5(b) for both identified and all other injuries.

For diagnostic tests, treatments, surgeries, services, USFDA approved prescription medication, DME and non-medical products, devices, services and activities identified below, the claimant's treating health care provider is required to obtain Precertification from NJPLIGA. Alternatively, the claimant or the treating health care provider may voluntarily agree to submit all proposed treatment to Precertification. Decision Point Review/Precertification requests must be submitted on the Attending Provider Treatment Plan ("APTP") form approved by the DOBI. Copies of this form may be requested from NJPLIGA by calling (908) 382-7100 or can be obtained at www.njguaranty.org or www.nj.gov/dobi/aicrapg.htm.

All requests for surgical procedures (CPT codes 10000-69999) require supplemental information 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, anesthesiologists, physician assistants and/or registered nurse first assistants as supported by the Centers for Medicare and Medicaid Services ("CMS") guidelines, anticipated post-operative services and care not included in the global fee period, including but not limited to, therapy, diagnostic testing and/or DME. This information shall be submitted on or with the Surgery Precertification Request for NJ PIP Claims Form which is available at www.njguaranty.org or by contacting NJPLIGA. Requests for surgeries that do not include the necessary information will be administratively denied as deficient until the required information is provided.

All written documentation provided to NJPLIGA in support of a Decision Point Review or Precertification request must be clinically supported and establish that prior to selecting, performing or ordering the administration of a treatment, diagnostic test, USFDA approved prescription medication or DME, the treating health care provider has:

1. Personally examined the claimant to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing, USFDA approved prescription medication or DME;
2. Physically examined the claimant including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological 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, USFDA approved prescription medication or DME; and
4. Recorded and documented those observations, positive and negative findings and conclusions on the claimant's medical records.

MANDATORY PRECERTIFICATION:

Precertification by NJPLIGA is not a guaranty of payment and, as such, shall not be used in any forum or venue including arbitration, alternative dispute resolution or court to imply, infer or indicate that payment should be made.

Mandatory Precertification applies to the following:

1. Non-emergency inpatient and outpatient hospital care including ancillary services and products, procedures and facility fees (Precertification request must include the necessity and duration of the hospital stay).
2. Non-emergency surgical procedures or surgery (performed in a hospital, ambulatory surgical facility or office) including ancillary services, products, procedures, facility fees, implants and post-operative care and/or supplies not included in the global fee period. The Precertification request must include the necessity for the procedure and the anticipated duration of the stay. Pursuant to N.J.A.C. 11:3-29.4 et seq., global fee periods and the necessity for co-surgeon and assistant surgeons will be determined based upon the CMS Physician Fee Schedule and Medicare Claims Manual which can be found at www.cms.gov.
3. Non-emergency inpatient and outpatient psychological/psychiatric services and/or testing including biofeedback.
4. Infusion therapy.
5. Extended care and rehabilitation facilities.
6. All outpatient care, including follow-up evaluations, for soft tissue/disc injuries of the claimant's neck, back and related structures not included within the diagnoses covered by the Care Paths.
7. Treatment, testing and/or DME relating to temporomandibular disorders and/or any oral facial syndrome.
8. Carpal tunnel syndrome.
9. All home healthcare.
10. DME with an aggregate cost or monthly rental in excess of $75.00 and/or monthly rental greater than thirty (30) days including DME and associated supplies, prosthetics and orthotics.
11. Non-medical products, devices, services, activities and associated supplies, not exclusively used for medical purposes or as DME with an aggregate cost or monthly rental in excess of $75.00.
12. Non-emergency medical transportation.
13. Non-emergency dental restoration.
14. All physical, occupational, speech, cognitive or other restorative therapy or body part manipulation, including follow up evaluations by the referring physician, except that provided for Identified Injuries in accordance with Decision Point Review.
15. Podiatry.
16. Audiology.
17. Bone scans.
18. Computerized muscle testing.
19. Work hardening.
20. Current perceptual testing.
21. Temperature gradient studies.
22. Vax D and DRX.
23. Psychological testing.
24. Interoperative neuromonitoring.
25. Videonystagmography ("VNG"), nystagmus, vestibular, balance or cognitive testing.
26. CAT/mylogram
27. Discogram
28. Prescriptions, including but not limited to, Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration when prescribed for more than three (3) times in a row, for a time period of more than ninety (90) days, or more than three (3) times in one (1) year or in excess of $75.00 for a single fill and/or a thirty (30) day supply.
29. Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.
30. All pain management treatment and services except that provided for Identified Injuries in accordance with Decision Point Review, including but not limited to the following:
    a) Acupuncture;
    b) Nerve blocks;
    c) Manipulation under anesthesia;
    d) Anesthesia when performed in conjunction with invasive techniques;
    e) Epidural steroid injections;
    f) Radio frequency/rhyzotomy;
    g) Biofeedback;
    h) Implantation of spinal stimulators or spinal pumps;
    i) TENS units (transcutaneous electrical nerve stimulation);
    j) PENS units (percutaneous electrical nerve stimulation);
    k) Electro-acupuncture devices; and
    l) Trigger point injections.
31. Non-emergency drug screening and/or drug testing, including but not limited to any technical analysis of urine, hair, blood, breath, sweat, saliva or other biological specimen used to detect the presence or absence of specified drugs or their metabolites, controlled substances, alcohol or drugs prohibited by law.

Decision Point Review/Precertification requirements shall not apply to diagnostic tests, treatments, USFDA approved prescription medications or DME administered or obtained within ten (10) days of the claimant's covered injury. However, such items may be reviewed retrospectively and must be medically necessary and causally related to the covered injury in order to be reimbursable.

DECISION POINT REVIEW/PRECERTIFICATION

During Decision Point Review/Precertification, the treating health care provider has the opportunity to explain any complicating factors that may require additional treatment or provide medical justification for diagnostic testing. Decision Point Review/Precertification will be performed upon receipt of the necessary medical information from the treating provider by facsimile.

The request must be faxed to (908) 382-7157.

Requests sent by any other means or to any other facsimile number will not be considered. Upon receipt of proper written documentation, NJPLIGA will either:

a) Authorize the treatment, diagnostic testing, USFDA approved prescription medication and/or DME;
b) Deny and/or modify the treatment, diagnostic testing, USFDA approved prescription medication and/or DME;
c) Request additional medical documentation; or
d) Advise that an Independent Medical Examination will be scheduled.

If NJPLIGA fails to do at least one (1) of the above four (4) things within three (3) business days after receipt of a request submitted on the appropriate form(s) to the appropriate facsimile number, the proposed treatment, diagnostic testing, USFDA approved prescription medication and/or DME is deemed to be authorized until a final determination is communicated to the treating health care provider. The decision to deny a request based upon medical necessity will be made by a health care provider.

Hours of Operation

The business day is 8:00 a.m. to 4:30 p.m., Monday through Friday. Note that "business days" do not include Saturdays, Sundays, State or Federal holidays or days that the office is closed due to severe weather, mandatory evacuation or a State of Emergency. The day a request or any other communication is received by NJPLIGA is not counted when calculating the number of business days.

Decision Point Review and Precertification requests must be submitted on the APTP Form approved by the DOBI. The following required information must be submitted to NJPLIGA in order to consider a request for Decision Point Review/Precertification:

1. Provider's name, address, telephone number, contact person and specialty.
2. History of the injury, prior injuries, previous medical history, current clinical findings.
3. ICD (International Classification of Diseases) diagnosis codes related to the injury.
4. Current claimant evaluation including objective clinical findings.
5. Results of completed diagnostic testing.
6. Amount and type of treatment received to date with documented response.
7. Proposed diagnostic tests for comparison to criteria contained in N.J.A.C. 11:3-4.5.
8. Proposed course of treatment consistent with subjective and objective findings.
9. Proposed CPT (Current Procedural Terminology), CDT (Current Dental Terminology), HCPCS (Healthcare Common Procedure Coding System) and procedural codes related to the diagnoses, including frequency and duration. Proper codes must be utilized for medical or dental treatments.
10. Date of re-evaluation for discharge or anticipated discharge date (Decision Point Review).
11. Legible notes.

All requests for surgical procedures, with the exception of minor surgery,[3] require supplemental information. This information should be submitted on or with the Surgery Precertification Request for NJ PIP Claims Form.

[3] Pursuant to N.J.A.C. 13:35-4A.3 "minor surgery" means surgery which can safely and comfortably be performed on a patient who has received no more than the maximum manufacturer recommended dose of local or topical anesthesia, without more than minimal pre-operative medication or minimal intra-operative tranquilization and where the likelihood of complications requiring hospitalization is remote. Minor surgery specifically excludes all procedures performed utilizing anesthesia services as defined in this section. Minor surgery also specifically excludes procedures which may be performed under local anesthesia, but which involve extensive manipulation or removal of tissue such as liposuction or lipo-injection, breast augmentation or reduction, and removal of breast implants. Minor surgery includes the excision of moles, warts, cysts, lipomas, skin biopsies, the repair of simple lacerations, or other surgery limited to the skin and subcutaneous tissue. Additional examples of minor surgery include closed reduction of a fracture, the incision and drainage of abscesses, certain simple ophthalmologic surgical procedures, such as treatment of chalazions and non-invasive ophthalmologic laser procedures performed with topical anesthesia, limited endoscopies such as flexible sigmoidoscopies, anoscopies, proctoscopies, arthrocenteses, thoracenteses and paracenteses. Minor surgery shall not include any procedure identified as "major surgery" within the meaning of N.J.A.C. 13:35-4.1.

This information will be compared to standards of good practice, standard professional treatment protocols and established practice parameters utilized by NJPLIGA. The medical necessity of proposed diagnostic tests will be evaluated based on the criteria contained in N.J.A.C. 11:3-4.5 and N.J.S.A. 39:6A-2(m).

NJPLIGA will provide its determination within three (3) business days following receipt of a properly submitted request. NJPLIGA's failure to respond within three (3) business days will allow a health care provider to continue treatment until the required determination is provided.

When an improperly submitted request is received, NJPLIGA will inform the treating health care provider what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation or information will be issued and will remain in effect until all requested information required to determine medical necessity regarding the requested treatment, testing, USFDA approved prescription medication and/or DME is received and a determination is rendered in accordance with this DPR plan.

Authorized testing, treatment and/or DME is only approved for the range of dates noted in the determination letter(s).

If a treating health care provider fails to follow the procedures listed below, all testing, treatment, USFDA approved prescription medication and/or DME completed after the last date in the range of dates indicated in the determination letter will be subject to a penalty co-payment of fifty percent (50%), even if the services are determined to be medically necessary and causally related to the accident. In order to avoid this penalty co-payment, treating health care providers must submit to NJPLIGA a written extension request, including the supporting reasons for the extension, when medically necessary and causally related treatment, diagnostic testing, USFDA approved prescription medication or DME is not completed within fourteen (14) days from the date in which the authorization period expired.

The request must be faxed to (908) 382-7157.

Requests sent by any other means or to any other facsimile number will not be considered.

INDEPENDENT MEDICAL EXAMINATIONS

NJPLIGA may request that the claimant attend an Independent Medical Examination ("IME"). If an IME is requested, the claimant will be notified of the appointment within seven (7) calendar days from the date that NJPLIGA notified all required parties that an IME will be scheduled, unless the claimant and NJPLIGA mutually agree to extend the time period for the scheduling. The IME will be conducted by a health care provider within the same specialty of the treating health care provider or by a board certified specialist with the requisite expertise in the area of medicine for which a test or treatment has been requested or a diagnosis has been rendered and will be conducted at a location reasonably convenient to the claimant.

Claimant must attend the IME and cooperate with NJPLIGA to schedule the examination. Claimant must bring valid photo identification to the IME. If claimant is non-English speaking, an interpreter of legal age must accompany the claimant to the IME. NJPLIGA will not provide an interpreter or reimburse for this expense. Claimant must bring copies of all medical records and diagnostic studies related to claimant's injury to the IME. Claimant must fully cooperate with the examining physician and may be asked to bring specific prescribed DME items to the examination. Failure to do so may jeopardize claimant's future benefits.

If it is necessary for claimant to reschedule the IME appointment, the claimant must contact NJPLIGA for approval at least three (3) business days prior to the scheduled appointment by phone at (908) 382-7100 or fax at (908) 382-7150. Approval to excuse attendance of a scheduled IME appointment and to reschedule the IME shall be at the sole discretion of NJPLIGA.

Except for non-emergent tests, surgery, procedures performed in ambulatory surgical centers, outpatient facilities and/or hospitals and invasive dental procedures, treatment may proceed while the IME is being scheduled and until the results become available. However, only medically necessary treatment related to the motor vehicle accident will be reimbursed and such treatment is subject to utilization review. If the IME provider prepares a written report concerning the IME, the claimant, or claimant's designee, shall be provided a copy of the report upon request.

The following will result in an unexcused failure to attend the IME:

1. Failure to present photo identification to the IME provider at the time of the examination.
2. Failure to be accompanied by an interpreter of legal age if the claimant is non-English speaking. NJPLIGA will not pay for any interpreter fees and/or costs.
3. Failure to attend any of the scheduled examination appointments for any unexcused reason.
4. Failure to provide to the examining physician all available medical records and diagnostic studies/tests before or at the time of the scheduled examination.

5. Failure to obtain approval from NJPLIGA to reschedule the IME at least three (3) full business days prior to the originally scheduled appointment. Approval shall be at the sole discretion of NJPLIGA.

If the claimant has two (2) or more unexcused failures to attend the scheduled IMEs, notification will be immediately sent to the claimant, or to claimant's designee and all health care providers treating the claimant. The notification will place the claimant and all treating health care providers on notice that all future treatment, diagnostic testing, USFDA approved prescription medication or DME for the injuries will not be reimbursable as a consequence of failure to comply with the DPR Plan.

Within three (3) business days after the IME is attended, NJPLIGA will notify the claimant and the treating health care provider of the results of the examination. If the results are not provided within three (3) business days of the IME, the treatment, testing, USFDA approved prescription medication and/or the provision of DME in that specialty may proceed until either the claimant and/or the treating health care provider has been notified that reimbursement for the treatment, testing, USFDA approved prescription medication or DME is not authorized.

DUTY TO COOPERATE

Claimant shall, as a condition to obtaining benefits from NJPLIGA, cooperate with NJPLIGA's investigation including, but not limited to, providing additional documentation, records or other items requested, written or recorded statements and examinations under oath ("EUOs") on any subjects reasonably related to or having nexus[4] to the claim being presented. As often as reasonably required by NJPLIGA, EUOs shall be conducted, not in the presence of any other claimants and/or health care providers, by a person designated by NJPLIGA even if statements or EUOs were previously obtained from the aforementioned parties. Such EUOs shall be conducted at times and locations reasonably convenient to the claimant who shall have the right to be represented by counsel. NJPLIGA will not reimburse the claimant for attendance at the EUOs, attorneys' fees or any other expenses related to the EUOs. A stenographic record shall be made of the EUOs and claimant shall subscribe to same.

VOLUNTARY UTILIZATION NETWORK (VUN)

For non-emergency benefits, certain goods and services may be secured through NJPLIGA or its designated Voluntary Utilization Network: Coventry Integrated Network ("Network"). All of the Network partners are part of Coventry Integrated Network's Managed Care Organization ("MCO") certification and meet the requirements of N.J.A.C. 11:3-4.8. These Networks provide excellent service and offer convenient locations throughout the State. In addition, the use of these Networks will allow the claimant's benefit dollars to go further. The following services are available through the Networks:

1. DME with an aggregate cost or monthly rental in excess of $75.00 including DME and supplies, prosthetics and orthotics.
2. Magnetic resonance imagery.
3. Computer assisted tomography scan.
4. Prescription drugs.
5. Electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)(1)-(3), except for needle EMG's, H-reflex and nerve conduction velocity tests performed together by the treating physician.
6. Services, equipment or accommodations provided by an Ambulatory Surgical Center.
7. Laboratory testing services.

The availability of the Network does not waive the requirement for Decision Point Review and Precertification of goods or services as required by this DPR Plan.

Upon notification to NJPLIGA of an injury claim, the claimant or claimant's designee will receive information regarding the DPR Plan including the availability of the Voluntary Utilization Network and the penalty assessed for failure to utilize the Network.

In addition, when NJPLIGA receives a request for goods and/or services, the claimant and/or claimant's treating healthcare provider will receive a Decision Point Review/Precertification determination letter advising of the options available to receive Network services and an explanation of the thirty percent (30%) co-payment penalty that may be assessed for failure to obtain these goods or services from the Network.

A thirty percent (30%) co-payment penalty shall apply if goods or services available through NJPLIGA or its designated Network are not procured through NJPLIGA or its designated Network. This penalty is in addition to any other policy or statutory deductible or offset, co-payment and penalty applicable under this DPR Plan. The thirty percent (30%) co-payment shall not apply to the failure to obtain laboratory testing services through the VUN.

[4] "Nexus" is defined as a point of causal intersection, link, reasonable relation or connection.

For information regarding the available Voluntary Utilization Network, the claimant, claimant's designee and/or claimant's treating health care provider may access NJPLIGA's website at www.njguaranty.org or call (908) 382-7100.

PENALTIES

The co-payment penalties set forth in the DPR Plan are in addition to any other policy or statutory deductible, co-payments or offsets.

Fifty Percent (50%) Co-Payment Penalty

NJPLIGA shall assess a fifty percent (50%) co-payment penalty for medically necessary diagnostic tests, treatments, USFDA approved prescription medications, surgeries (including ancillary services, procedures and facility fees), DME and non-medical products, devices, services and activities that are incurred without first complying with the provisions of this DPR Plan. The treating health care provider's non-compliance with the provisions of this DPR Plan may trigger this additional co-payment penalty. No penalty under this provision will be applied within the first ten (10) days after the accident.

Non-compliance, which shall result in the imposition of a fifty percent (50%) co-payment penalty, includes any of the following:

1. Failure to follow the Precertification requirements of this DPR Plan including the submission of the Surgery Precertification Request for NJ PIP Claims Form when required as specified in this DPR Plan.
2. Failure to follow the Decision Point Review requirements of this DPR Plan.
3. Failure to provide clinically supported findings for medical procedures, treatments, diagnostic tests, USFDA approved prescription medications services, non–medical products, devices and activities or DME at the time of the request for Decision Point Review/Precertification.

The fifty percent (50%) co-payment penalty shall apply to the eligible charge for medically necessary diagnostic tests, treatments, USFDA approved prescription medications or DME that were provided between the time notification to NJPLIGA was required and the time that proper notification is made and NJPLIGA has an opportunity to respond in accordance with this DPR Plan.

Thirty Percent (30%) Co-Payment Penalty

Non-compliance, which shall result in the imposition of a thirty percent (30%) co-payment penalty, includes any of the following:

1. Failure to secure DME through NJPLIGA or its designated vendor(s) or Network.
2. Failure to secure specified diagnostic imaging/testing through NJPLIGA or its designated vendors(s) or Network.
3. Failure to secure prescription drugs through NJPLIGA or its designated vendor(s) or Network.
4. Failure to secure ambulatory surgery through NJPLIGA or its designated vendor(s) or Network.

INTERNAL APPEAL PROCESS

There are two (2) types of internal appeals:

1. **Pre-Service Appeals** - Treatment appeals about the medical necessity of future treatment or testing that was requested by the treating health care provider on a properly completed Decision Point Review/Precertification request; and
2. **Post-Service Appeals** - Administrative appeals for all other types of adverse decisions, including but not limited to, bill disputes, Decision Point Review/Precertification penalties and coding discrepancies.

All appeals shall be filed using the appropriate Pre-Service or Post-Service Appeal Forms which are available at www.njguaranty.org or by contacting NJPLIGA at (908) 382-7100. All Forms must be completed fully, including the claim number, date of loss, claimant name and clearly identify the adverse decision that is the basis for the appeal. Treatment appeals must specifically explain the reason the treatment request should be reconsidered and, if applicable, provide supporting medical/dental documentation and/or test results that were not submitted with the original request for treatment. It is not necessary to resubmit the documentation previously submitted.

Incomplete or untimely filing of an appeal Form will result in an administrative denial.

Pre-Service Appeal Forms must be faxed to (908) 382-7160.

Post-Service Appeal Forms must be faxed to (908) 382-7158.

Appeals sent by any other means or to any other facsimile number will not be considered.

Pre-Service Appeals

Pre-Service Appeals shall be submitted **no later than thirty (30) calendar days** after the treating health care provider has received notice of the adverse decision that is the basis for the appeal. Pre-Service Appeals may not be submitted as administrative appeals. Provided that additional necessary medical information is submitted with the Pre-Service Appeal, NJPLIGA will render a decision within fourteen (14) calendar days of receipt of the pre-service appeal form and all necessary supporting documentation, unless it is determined that a peer review or an IME is appropriate. The treating health care provider will be notified within fourteen (14) calendar days if a peer review or IME is required.

Pre-Service Appeals that are submitted after thirty (30) calendar days will be considered untimely. An incomplete or untimely appeal does not constitute an appeal. If a provider misses the deadline to submit a Pre-Service Appeal, he or she may submit another Decision Point Review or Precertification request for the treatment or testing. Submission of information identical to the initial information submitted in support of the treatment request will not be accepted as a request for a Pre-Service Appeal.

Post-Service Appeals

As a condition precedent to filing an arbitration or litigation, a claimant or health care provider who has rendered services and accepted a Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements must submit a written request for a Post-Service Appeal of any and all disputes, including but not limited to, any claims for unpaid medical bills for medical/dental expenses and for unpaid services 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. Post-Service Appeals cannot be submitted as treatment appeals.

In order to be considered valid, all Post-Service Appeals must be submitted **within sixty (60) calendar days** of the adverse decision **and at least forty five (45) calendar days** prior to initiating arbitration or litigation. In addition, all requests for Post-Service Appeals must include, as the cover page, a fully completed PIP Post-Service Appeal Form and must be faxed to NJPLIGA at (908) 382-7158. Only requests for Post-Service Appeals will be accepted at this number. Requests for Decision Point Review, Precertification or Pre-Service Appeals will not be accepted at this number. This Form is available at www.njguaranty.org or may be obtained by contacting NJPLIGA at (908) 382-7100. An incomplete or untimely appeal does not constitute an appeal.

NJPLIGA will render a decision within thirty (30) calendar days from the date of the appeal. NJPLIGA will not accept or respond to appeals that are sent to any other facsimile number or by any other method or that fails to include a fully completed PIP Post-Service Appeal Form. Only requests for PIP Post-Service Appeals will be accepted at this number.

Independent Medical Exam Needed for an Appeal

If it is determined that an IME is necessary to respond to either a treatment or administrative appeal, the time periods to respond to the appeal request shall start after the IME has been conducted and the report received from the examining physician.

After the IME has been conducted and the report has been received, the treating health care provider will be notified, by facsimile, of the decision on Pre-Service Appeals within ten (10) business days or Post–Service Appeals or administrative appeals within thirty (30) business days.

Arbitration

Pursuant to N.J.A.C. 11:3-5.1, any properly submitted appeal that has not been resolved through the Internal Appeal Process may be submitted for personal injury protection dispute resolution. As of the filing of this plan, New Jersey has assigned Forthright as the administrator of the New Jersey PIP dispute resolution process pursuant to N.J.S.A. 39:6A-1 et seq. If DOBI changes the administrator of the PIP dispute resolution process, information about the new administrator will be available on the DOBI web site and this DPR Plan shall remain in full force and effect. Forthright may be contacted for filing information at (732) 271-6100. Forms, rules and procedures are also available on Forthright's website at www.nj-no-fault.com. The claimant or treating health care provider agrees to indemnify and hold NJPLIGA harmless for any legal fees and/or costs incurred by NJPLIGA as a result of the claimant and/or treating health care provider's failure to utilize the Internal Appeal Process prior to filing with Forthright.

To the extent permitted by law, the results of the Forthright arbitration filing shall be final and binding, with no right of appeal.

Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements ("Conditional Assignment")

As a condition of assignment of claimant's benefits:

1. A treating health care provider must obtain a fully executed Conditional Assignment in order to be paid directly by NJPLIGA for covered services. NJPLIGA's CONDITIONAL ASSIGNMENT OF PERSONAL INJURY PROTECTION BENEFITS & DISCLOSURE REQUIREMENTS form is the only valid assignment of benefits. A copy of this Conditional Assignment must be furnished to NJPLIGA upon request.
2. The Conditional Assignment must be signed by the claimant and the treating health care provider or an agent authorized to act on behalf of the provider. By executing the Conditional Assignment, or having it executed, the treating health care provider agrees to be bound by the terms of the Assignment and other applicable terms, conditions and duties as set forth in all applicable statutes, rules, regulations and NJPLIGA's DPR Plan. The treating health care provider agrees that NJPLIGA has the right to reject, terminate or revoke the Conditional Assignment at any time.
3. Consistent with N.J.S.A. 39:6A-13(b), N.J.S.A. 17:33A-1 et seq., or other applicable law, the treating health care provider agrees to the production and inspection of documents, objects and facilities reasonably relevant to or having nexus to the claim being presented. This includes but is not limited to:
    a. Allowing and providing NJPLIGA or its agent(s) with the authority to inspect original documents and credentialing reasonably relevant to or having nexus to the claim being presented that are in the possession of the treating health care provider, its agent(s), or which can be obtained by the treating healthcare provider or its agent(s) using reasonable efforts.
        i. Inspections will be made during mutually convenient times but within thirty (30) days of any such request;
        ii. Upon mutual agreement, the inspection of documents may be waived by NJPLIGA if copies are provided within thirty (30) days of any such request and the copies are determined to be suitable by NJPLIGA for the purposes of its investigation.
    b. Allowing NJPLIGA or its agent(s) to verify by inspection of the premise(s), or other location(s) where any professional services and/or treatment or therapy were rendered that the equipment in such premise(s) or location(s) matches the services billed. Such inspections will be conducted at a mutually convenient time and date within thirty (30) days of any such request.
4. The treating health care provider agrees to cooperate with any investigation conducted by NJPLIGA including, but not limited to, providing interviews, written or recorded statements and EUOs on any subjects reasonably related to or having nexus to the claim being presented. As often as reasonably required by NJPLIGA, EUOs shall be conducted, not in the presence of any other claimants and/or health care providers, by a person designated by NJPLIGA, even if statements or EUOs were previously obtained from the aforementioned parties. Such EUOs shall be conducted at times and locations reasonably convenient to the treating health care provider who shall have the right to be represented by counsel. NJPLIGA will not reimburse the treating health care provider for attendance at the EUOs, attorneys' fees or any other expenses related to the EUOs. A stenographic record shall be made of the EUOs and the treating health care provider shall subscribe to same.
5. The treating health care provider acknowledges that Decision Point Review/Precertification by NJPLIGA is only a determination of medical necessity and is not a guaranty of payment. Decision Point Review/Precertification does not confirm or verify eligibility for coverage, statutory benefits or payment. Decision Point Review and Precertification by NJPLIGA shall not be used in litigation in any forum, venue or court proceeding to imply, infer or indicate that payment should be made except as to an issue of medical necessity.
6. The treating health care provider agrees to hold harmless the claimant and NJPLIGA for any reduction of benefits caused by the provider's failure to fully comply with the terms and conditions of the DPR Plan.
7. The treating health care provider irrevocably agrees to follow NJPLIGA's internal appeals processes and to exhaust such processes prior to submitting any unresolved disputes through the New Jersey PIP dispute resolution system pursuant to N.J.S.A. 39:6A-1 et seq.

EXHIBIT 2

NJPLIGA New Jersey Property-Liability Insurance Guaranty Association

New Jersey Surplus Lines Insurance Guaranty Fund
Unsatisfied Claim and Judgment Fund
Workers' Compensation Security Fund

233 Mount Airy Road ❖ Basking Ridge, New Jersey 07920
Tel: (908) 382-7100 ❖ www.njguaranty.org

SURGERY PRECERTIFICATION REQUEST FOR NJ PIP CLAIMS
(This does not apply to EMERGENCY PROCEDURES)
Fax (908)382-7157

Request Date: _____
Physician Name: _____
Telephone No.: _____
Fax No.: _____
TIN: _____

Patient Name: _____
Claim No.: _____
Date of Loss: _____

Please complete below:
Include documentation to support the need for and causal relationship of surgery (i.e., MRIs, CT scans, Discogram, EMG and most recent office notes).

Surgical Procedure Description: _____

_____

_____

CPT/Dental Procedure Code(s)*: _____

_____

**Subject to review and substantiation with operative report.*

ICD Diagnosis Code(s): _____

Name of Hospital or ASC where procedure will be performed: _____

_____

Please check the appropriate box:

☐ I do not anticipate requiring an assistant surgeon or co-surgeon.

☐ I propose using a co-surgeon/assistant surgeon/physician assistant/RNFA (circle the one that applies)**.
Name: _____

☐ I propose using two or more surgeons. Name(s)/Role(s): _____

_____

☐ Post-operative care beyond that included in the global fee period is required (Specify type of care/services i.e., PT with frequency and duration, DME, etc.)**.

_____

_____

_____

☐ Inpatient admission required. ☐ Same Day Surgery. Proposed Surgery Date: _____

**** REQUESTS FOR CO-SURGEONS AND ASSISTANT SURGEONS MUST MEET CMS GUIDELINES**

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 and Medicaid Services (CMS) Physician Fee Schedule and Medicare Claims Manual which can be found at www.cms.gov.

EXHIBIT 3

MetLife®

IMPORTANT NOTICE: NOTIFICATION OF CHANGES MADE TO DECISION POINT REVIEW PLAN

Metropolitan Property and Casualty Insurance Company and Affiliates routinely review our protocols and procedures surrounding the implementation of its Decision Point Review (DPR) plan that governs the administration of Personal Injury Protection (PIP) claims. Our DPR plan is administered by Prizm, LLC. You are receiving this letter because you have recently treated or are currently treating a patient impacted by these changes. Changes to our DPR plan will become effective on April 17, 2017. Some of the changes are highlighted below:

Under the section entitled **Decision Point Review/Pre-Certification Requests**

*The following updated list includes **treatment, test and medical services that are subject to Pre-Certification** according to Metropolitan Property and Casualty Insurance Company and Affiliates' Plan:*

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Infusion therapy
- Extended Care Rehabilitation Facilities
- All Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Path's.
- All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except that provided for identified injuries in accordance with Decision Point Review.
- All Outpatient psychological/psychiatric treatment/testing and/or services
- All pain management/pain medicine services except as provided for identified injuries in accordance with Decision Point Review
- Home Health Care
- Acupuncture
- Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $50.00 or rental in excess of 30 days
- Non-emergency medical transportation with a round trip transportation expense in excess of $75.00
- Non-Emergency dental restorations
- Temporomandibular disorders; any oral facial syndrome
- Current Perception Testing

- Computerized Muscle Testing
- Nutritional Supplements
- All treatment and testing related to balance disorders
- Bone Scans
- Podiatry
- Carpal tunnel syndrome
- Vax-D/DRX type devices
- Prescriptions costing more than $50.00 per month
- Manipulation under anesthesia
- Audiology testing
- Nerve blocks
- Epidural steroid injections
- Trigger point injections
- Radiofrequency / rhizotomy
- Biofeedback
- Implantation of spinal stimulators or spinal pumps
- Urine drug testing for prescription management or drug abuse identification
- Any and all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPC code

Under the section entitled **Internal Appeals Process**

*The following is the new **Appeals Process** according to Metropolitan Property and Casualty Insurance Company and Affiliates' Plan:*

1. In accordance with NJAC 11:3-4.7B, Prizm's appeal process is as follows:
   A. Pre-Service appeals
      i. If a request for medical services is denied or modified by a Physician Advisor Review or an IME, the treating provider must request a reconsideration of the physician recommendation prior to the performance or issuance of the requested service. This request must be made in writing within thirty (30) days of receipt of the recommendation to deny or modify the DPR or Pre-Certification request. The request must include a properly completed Pre-Service Appeal Form (as defined in section ii below) in accordance with NJAC 11:3-4.7(d), the original Attending Provider Treatment Plan (APTP) being appealed, the APTP Decision/Response document being appealed, an appeal rationale narrative, the appealing physician's signature and reason(s) for reconsideration along with any additional supporting documentation. If the required information is not submitted at the time the pre-service appeal is received, the appeal will

be denied administratively and will not be addressed. The provider will be notified of the insufficiencies contained in their appeal submission and will be given the opportunity to resubmit correctly.

ii. A properly completed Pre-Service Appeal Form must include:
- Date Appeal Submitted (box 1)
- Receipt Date of Adverse Decision (box 2)
- All Claim Information (boxes 3-5)
- All Patient Information (boxes 6-13)
- Provider/Facility Information (boxes 14-25)
- Required Documents attached
  - Original APTP Form
  - APTP Decision/Response document
  - Appeal rationale narrative
  - Additional new supporting records
- Pre-Service Appeal Issues (boxes 30-34 as appropriate)
  - Only one APTP should be submitted per Pre-Service Appeal Form. If multiple APTP's require a pre-service appeal, a separate Pre-Service Appeal Form should be submitted for each unique APTP.
- Signature of Provider (box 35)

iii. The properly completed Pre-Service Appeal Form and required attached documents should be submitted to Prizm via fax at (856) 596-6300, electronically at Documents@prizmllc.com or mailed to PO Box 986, Marlton, NJ 08053. The form can be found on Prizm's website www.prizmllc.com

iv. It may be determined that an Independent Medical Examination is necessary. If this is the case, the appointment shall be scheduled within seven (7) calendar days of receipt of the appeal request unless the injured person agrees to extend the time period. The examination shall be scheduled with a provider of the same discipline and the most appropriate specialty related to the treating diagnoses as the treating provider and within a location reasonably convenient to the patient.

v. Prizm's written response to the appeal will be communicated to the provider listed on the Pre-Service Appeal Form (boxes 14-25) by fax or mail within fourteen (14) days after receipt of the appeal request and any supporting documentation.

B. Post-Service appeals

i. If the appeal is for any issue, other than treatment denials or modifications done by a Physician Advisor Review or an IME, subsequent to the performance or issuance of the services, a treating provider must request reconsideration through Prizm. This request must be made in writing within ninety (90) days of receipt of the explanation of benefits and at least forty-five (45) days prior to initiating alternate dispute resolution pursuant to N.J.A.C 11:3-5. The request must include a properly completed Post-Service Appeal Form in accordance with NJAC 11:3-4.7(d) (as defined in section ii below),

the original Bill (HCFA/UB), the Explanation of Benefit/Payment, the signature of the treating provider and reason(s) for reconsideration along with any additional supporting documentation, including UCR information when applicable. If the required information is not submitted at the time the post-service appeal is received, the appeal will be denied administratively and will not be addressed. The provider will be notified of the insufficiencies contained in their appeal submission and will be given the opportunity to resubmit correctly.

ii. A properly completed Post-Service Appeal Form must include:
   - Date Appeal Submitted (box 1)
   - Receipt Date of Adverse Decision (box 2)
   - All Claim Information (boxes 3-5)
   - All Patient Information (boxes 6-13)
   - Provider/Facility Information (boxes 14-25)
   - Required Documents attached
     - Original Bill (HCFA/UB)
     - Explanation of Benefit/Payment
     - Appeal rationale narrative
   - Post-service Appeal Issues (boxes 30-38 as appropriate)
     - Only one EOB ID should be submitted per Post-Service Appeal Form. If multiple EOB's require a post-service appeal, a separate Post-Service Appeal Form should be submitted for each unique EOB ID.
   - Signature of Provider (box 39)

iii. The properly completed Post-Service Appeal Form and required attached documents should be submitted to Prizm via fax at (856) 596-6300, electronically at Documents@prizmllc.com or mailed to PO Box 986, Marlton, NJ 08053. The form can be found on Prizm's website www.prizmllc.com.

iv. Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within thirty (30) days after the receipt of the appeal form and any supporting documentation.

C. One-Level Appeal Requirement

i. Each issue shall require one internal appeal submission prior to making a request for alternate dispute resolution. A request that has been denied administratively does not constitute an appeal. A pre-service appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than a post-service appeal of what the insurer should reimburse the provider for that same service. If a provider submits a pre-service appeal or the modification or denial of treatment by a Physician Advisor Review or an IME and subsequently performs the services and receives an EOB denial on the basis of the same PAR or IME, the one-level appeal requirement has

been met and the provider is no longer able to appeal the same issue as a post-service appeal.

Should you have any questions or concerns after reviewing the material included in this letter and in the DPR plan listed on Prizm's website www.prizmllc.com, please contact the undersigned.

Sincerely,

Danielle Yeager
Claims Manager
1-800-854-6011 Ext 8642

EXHIBIT 4

NJM Insurance Group

301 Sullivan Way, West Trenton, NJ 08628
609-883-1300 / www.NJM.com

DECISION POINT REVIEW PLAN REQUIREMENTS

IMPORTANT INFORMATION ABOUT YOUR NO-FAULT MEDICAL COVERAGE

For NJM Insurance Group insureds seeking Personal Injury Protection (PIP) benefits

Please read this information carefully and share it with your health care providers.

The Automobile Insurance Cost Reduction Act became law in May 1998 and established certain obligations which you must satisfy so that coverage for medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident may be provided. During the course of your claim, you may be contacted by a company that is assisting your PIP Claims Representative, and requested to attend an Independent Medical Examination. Failure to abide by the following obligations may affect the authorization for medical treatment, diagnostic testing and durable medical equipment.

YOUR OBLIGATIONS

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**, you or your attending health care provider must give us 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 your PIP Claims Representative. If you or your attending health care provider 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 your 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 your attending health care provider considers 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 you or your attending health care provider must notify us by supplying 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 you or your attending health care provider fail to submit diagnostic testing 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 your bills 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 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. In addition to the voluntary network described above, NJM makes available preferred medical providers, including various medical specialists, hospitals, outpatient facilities and urgent care facilities. NJM's preferred providers have facilities located throughout the state. Information regarding our preferred medical providers is available to you at http://www.NJM.com/Auto/Auto-Preferred-Medical-Providers.asp or by contacting your PIP Claims Representative. The use of these preferred medical providers is strictly voluntary and is provided as a service to you. No additional co-payment will be applied if you choose to use a provider that is not on this list of preferred medical providers.
5. You or your attending health care provider must obtain **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/or 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.

6. We encourage you or your attending health care provider 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 treatment 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 your attending health care provider must submit a request for **decision point review** or **precertification** for any treatment or testing that varies from the approved treatment plan.
7. 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 five, 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 and/or your attending health care provider. Telephonic responses will be followed up with a written authorization, denial or request for more information within 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 you agree to extend the time period, and will notify you or your designee of the scheduled date. Pursuant to regulation, the medical examination will be conducted at a location reasonably convenient to you. The examination will be conducted by a provider in the same discipline as the attending health care provider. Upon our request, you or your attending health care provider must supply medical records and other related information to the examining provider at or before the time of the examination. If you are non-English speaking, then an English speaking interpreter must accompany you to the examination. No interpreter fees or costs will be compensable. If unable to attend the scheduled examination, you must notify us at least three (3) business days prior to the examination. **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 your attending health care provider 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 THE UNEXCUSED FAILURE TO ATTEND AN INDEPENDENT MEDICAL EXAMINATION

IT IS IMPORTANT THAT YOU ATTEND ALL SCHEDULED IMEs. YOU SHOULD BE AWARE THAT YOUR UNEXCUSED FAILURE TO ATTEND TWO OR MORE SCHEDULED IMES MAY RESULT IN NOTIFICATION TO YOU AND YOUR HEALTH CARE PROVIDERS 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.

8. 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.
9. 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 treatment, diagnostic testing 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, diagnostic 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 your 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 five above, you or your attending health care provider must notify us by providing 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 your attending health care provider 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 been provided, you or your attending health care provider 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 request 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 for 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 would like us to pay your provider of service benefits directly, you must sign an Assignment of Benefits agreement. As a condition of assignment, your provider must follow the requirements of this **Decision Point Review** Plan and shall hold you harmless for penalty co-payments imposed based on your provider's failure to follow the requirements of our **Decision Point Review** Plan. Failure to comply with (1) our **Decision Point Review** Plan Requirements, (2) the 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 into 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/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.

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 (APTP) form to submit **decision point review** and **precertification** requests. No other form will be accepted. A copy of the APTP 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 code(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 and 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 your or your provider's convenience, 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.

NJM INSURANCE GROUP
New Jersey Manufacturers Insurance Company
New Jersey Re-Insurance Company
New Jersey Casualty Insurance Company
New Jersey Indemnity Insurance Company

EXHIBIT 5

GEICO
Decision Point Review Plan
and
Precertification Requirements

DECISION POINT REVIEW

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 soft tissue injuries of the neck and back, collectively referred to as the Identified Injuries. The **Care Paths** provide that treatment be evaluated at certain intervals called **Decision Points**. On the **Care Paths**, **Decision Points** are represented by hexagonal boxes. At decision points the **Insured**/Eligible Injured Person or treating health care provider must provide us information about further treatment that is intended to be provided. This is called a **Decision Point Review.**

In addition, the administration of any diagnostic tests set forth in N.J.A.C. 11:3-4.5(b) is subject to **Decision Point Review** regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Department of Banking and Insurance's website at http:/www.state.nj.us/dobi/pipinfo/aicrapg.htm or by calling AUTO INJURY SOLUTIONS (AIS), Inc at 877-308-6599. The Informational Letter to the Insured/Eligible Injured Person/Providers and the Decision Point Review Plan are accessible on GEICO's website at http://www.geico.com/information/states/nj/personal-injury-protection/ (scroll down to Losses Occurring On or After October 1, 2012).

We will advise the **Insured and/or Eligible Injured Person** of the care path requirements upon notification to us of a claim filed under Personal Injury Protection. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury, however only reasonable, medically necessary and treatment related to the motor vehicle accident will be reimbursed.

We will review the course of treatment at various intervals (**Decision Points**), unless a comprehensive treatment plan has been precertified by us. In order for us to determine if additional treatment or the administration of a test is medically necessary, the treating healthcare provider or the **Insured and/or Eligible Injured Person** must provide us with reasonable prior notice together with appropriate, legible, clinically supported findings that the anticipated treatment or test is medically necessary. In order to submit a decision point review and/or precertification request, your treating health care provider must submit a completed Attending Provider Treatment Plan (APTP) form via fax to (866) 257-2323 along with clinically supported findings that support the treatment, diagnostic tests or durable medical equipment requested. A copy of the APTP form can be found on the New Jersey Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm and at http://www.geico.com/information/states/nj/personal-injury-protection/. We will review this notice and supporting materials within three (3) business days. **Business days is defined as Monday through Friday 9 AM to 5:30 PM EST excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency.**

Following our review, we have the option to:

a. Recommend authorization of reimbursement for the treatment, test, durable medical equipment, prescription medication; or

b. Recommend denial of reimbursement for the treatment, test, durable medical equipment, prescription medication where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity; or

c. Recommend modification/partial certification of reimbursement for the treatment, test, durable medical equipment, prescription drugs where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity for the treatment plan requested; or

d. Request additional documentation from the attending providers documentation when the submitted documentation is illegible; or

e. Schedule a physical examination of the **Insured and/or Eligible Injured Person** where the notice and supporting materials are insufficient to authorize, deny, or modify reimbursement or further treatment, test, durable medical equipment or prescription medication; or

f. Advise you that the DPR/Pre-certification request cannot be processed as the request is incomplete due to the lack of, or an incomplete Attending Provider Treatment Plan which is mandated to be submitted with every DPR/Precertification request as per New Jersey Department of Banking and Insurance on the State mandated form. A submitted Attending Provider Treatment Plan is considered to be incomplete if it lacks information that is vital to determining medical necessity. A submitted Attending Provider's Treatment Plan must be signed by the attending health care provider and dated.

If we request a physical or mental examination:

a. The appointment for the examination will be scheduled within seven (7) calendar days of our receipt of the notice of additional treatment or tests, unless the **Insured and/or Eligible Injured Person** agrees to extend the time period;

b. The physical or mental examination will be conducted by a provider in the same discipline as the treating provider;

c. The examination will be conducted at a location reasonably convenient for the **Insured and/or Eligible Injured Person.** If unable to attend the examination, the **Insured and/or Eligible Injured Person** must notify AIS, Inc at (888)701-5692, at least three (3) business days before the examination date. Failure to comply with this requirement will result in an unexcused absence.

   - Failure to attend the physical or mental examination will be excused if the Insured/Eligible Injured Person notifies AIS, Inc at least three (3) business days before the examination date of his or her inability to attend the examination. The burden is on the Insured/Eligible Injured Person to prove that proper notice was provided. Another examination will be scheduled to occur within thirty five (35) calendar days.

d. The **Insured and/or Eligible Injured Person** must, if requested, provide medical records, diagnostic imaging films, test results and other pertinent information to the examining provider conducting the examination. In addition, the **Insured and/or Eligible Injured Person** may be requested to bring prescribed electro-stimulation devices and/or supports/braces to the examination. The requested records and/or items must be provided no later than the time of the examination. Failure to comply with this requirement will be considered an unexcused absence.

e. The **Insured and/or Eligible Injured Person** must supply proper identification at the examination. A photo ID is required. Failure to supply the proper identification may constitute an incomplete IME until the proper documents are obtained. If the **Insured and/or Eligible Injured Person** is non-English speaking, then an English speaking interpreter must accompany the **Insured and/or Eligible Injured Person** to the examination. No interpreter fees or costs will be compensable. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

f. Examinations will be scheduled to occur within thirty-five (35) calendar days of receipt of the request for additional treatment/test or service.
   - If an **Insured and/or Eligible Injured Person** has an excused failure to attend a scheduled IME and does not reschedule the IME within thirty-five (35) calendar days of the original IME date, the failure to attend the original IME will be unexcused.
   - The **Insured and/or Eligible Injured Person** must attend examinations scheduled to occur beyond thirty-five (35) calendar days of receipt of the request for additional treatment/test or service. Failure to attend an examination scheduled to occur more than thirty-five (35) calendar days after receipt of the request will be considered an unexcused absence.

g. When the IME is scheduled the **Insured and/or Eligible Injured Person**, his designee if noted, and health care provider(s) will be given notice of the examination date, time and location. We will also inform all health care providers providing treatment for the diagnosis (and related diagnoses) contained in the APTP form. The examination notice details the consequences for more than one unexcused failure to attend. If the **Insured and/or Eligible Injured Person** has two or more unexcused failures to attend a scheduled exam of the same specialty, notification will be sent to the **Insured and/or Eligible Injured Person**, his designee if noted, and all health care providers providing treatment for the diagnosis (and related diagnoses) contained in the APTP form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment and/ or prescription medication required for the diagnosis (and related diagnoses) contained in the APTP form will not be reimbursable as a consequence of failure to comply with the Plan. Except for surgery, procedures performed in ambulatory surgical centers, and invasive dental procedures, treatment may proceed while the IME is being scheduled and until the results become available. However, only medically necessary treatment related to the motor vehicle accident will be reimbursed.

Examples of the **Insured and/or Eligible Injured Person's** unexcused failures to attend the exam may include but are not limited to one of the following:

- Failure to provide the medical records, diagnostic imaging films, test results and other pertinent information and/ or items as requested, before or on the day of examination;
- Failure to reschedule the examination with three (3) or more business days;
- Failure to present valid photo identification or any form of identification at the time of the examination
- Failure to be accompanied by an English interpreter if the **Insured and/or Eligible Injured Person** is non-English speaking;
- Failure to attend an examination scheduled to occur beyond thirty-five (35) calendar days of the receipt of the request of additional treatment/test or service;
- Failure to cooperate fully with the examining physician.

We will notify the **Insured and/or Eligible Injured Person**, or his designee, and the health care provider of our decision to recommend authorization or denial of reimbursement for the treatment or test as promptly as possible, but no later than three (3) business days following the examination. The notification of our decision will be by fax or mail. Any recommendation of denial for reimbursement of further treatment / tests or service will be based on the determination of a physician or dentist. If the examining provider prepares a written report concerning the examination, the **Insured and/or Eligible Injured Person** , or his designee, shall be entitled to a copy of the report upon request. If we fail to respond to the **Insured and/or Eligible Injured Person** within three (3) business days after receiving the required notification and supporting medical documentation at a decision point, then the health care provider is permitted to continue the course of treatment until we provide the required notice.

The following is a list of specific diagnostic tests subject to Decision Point Review:

- Brain Mapping
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Computer Assisted Tomographic Studies (CT, CAT Scan)
- Dynatron/Cybex Station/Cybex Studies; and any range of muscle motion testing
- Video-fluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography (needle EMG)
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Magnetic Resonance Imaging (MRI)
- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Thermogram/Thermography
- All diagnostic test identified in NJAC 11:3-4.5(b) for identified and all other injuries
- Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation.

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. 11:3-4.5(a):

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation
- Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Personal Injury Protection coverage

MANDATORY PRECERTIFICATION

If the **Insured and/or Eligible Injured Person** does not have an Identified Injury, we will require that the **Insured and/or Eligible Injured Person** or their health care provider request precertification for the services, treatments and procedures outlined in Exhibit A which includes, but is not limited to: diagnostic test(s), durable medical equipment, prescription supplies, or otherwise potentially covered medical expense benefits. In the event that an **Insured and/or Eligible Injured Person** is injured in an automobile accident, the **Insured and/or Eligible Injured Person** or the health care provider should contact AIS, Inc at 877-308-6599 in order to request precertification. In order to submit a decision point review and/or precertification request, your treating health care provider must submit a completed attending provider treatment plan (APTP) form via fax to 866-257-2323 along with legible and clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. A properly submitted APTP form must be completed in its entirety and must include: the Insured/Eligible Injured Person's full name and birth date, the claim number, the date of the accident, diagnoses/ICD-9 codes or ICD-10 codes, each CPT code requested including frequency, duration, signature of the requesting physician and date of signature. A copy of the Attending Provider Treatment Plan form can be found on the New Jersey Department of Banking and Insurance website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or on GEICO's website at http://www.geico.com/information/states/nj/personal-injury-protection/.

Precertification will not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury; however, only medically necessary treatment and/or testing which is related to the motor vehicle accident will be reimbursed.

Our approval of requests for precertification will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, the medical protocols adopted in N.J.A.C. 11:3-4 recognized by the Commissioner of Banking and Insurance. Our final determination of the medical necessity of any disputed issues shall be made by a physician or dentist as appropriate for the injury and treatment contemplated. The **Insured and/or Eligible Injured Person** or their health care provider must provide us with reasonable prior notice of the anticipated services, treatments and procedures as outlined above, as well as, the appropriate clinically supported findings to facilitate timely approval. When appropriate, the health care provider may submit a **comprehensive treatment plan** for precertification.

The IME and DPR requirements and response options outlined in Decision Point Review above apply to Pre-Certification.

PENALTY/CO-PAYMENTS AND THE DECISION POINT REVIEW PROCESS

If a request for Decision Point Review or Precertification is not submitted as required, or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty (50) percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment under the Personal Injury Protection coverage.

The additional co-payment of fifty (50) percent for failure to pre-certify treatment will not apply if we have received the required notice, supporting medical documentation, and have failed to respond within three (3) business days to authorize or deny reimbursement of further treatment or tests. Our failure to respond within three business days will allow a health care provider to continue treatment until we provide the required notice.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payment (if applicable)
2. Insured Deductible
3. Insured Co-payment

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

GEICO requires that the Insured/Eligible Injured Person advise and inform them about the injury and the claim as soon as possible after the accident and periodically thereafter. This may include the production of information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. If this information is not supplied as required, GEICO shall impose an additional co-payment as a penalty which shall be no greater than:

a) Twenty five (25) percent when received thirty (30) or more calendar days after the accident; or b) Fifty (50) percent when received sixty (60) or more calendar days after the accident.

VOLUNTARY PRECERTIFICATION

Health care providers are encouraged to participate in a Voluntary Precertification process by providing AIS, Inc with a comprehensive treatment plan for both identified and other injuries.

AIS, Inc will utilize nationally accepted criteria and the medical protocols adopted in NJAC 11:3-4 to work with the health care provider with the intent to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.

In consideration for the health care provider's participation in the voluntary precertification process, the bills that are submitted, when consistent with the precertified services, will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.6. In addition, having an approved comprehensive treatment plan means that as long as treatment is consistent with the agreed upon comprehensive treatment plan, additional notification to AIS, Inc is not required.

VOLUNTARY NETWORKS

AIS, Inc has established networks of pre-approved vendors that can be recommended for the provision of certain services, diagnostic tests, **electrodiagnostic tests,** durable medical equipment and/or prescription supplies. **Insured/Eligible Injured Persons** are encouraged, but not required, to obtain certain services, diagnostic tests, durable medical equipment and/or prescription supplies from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy. If they use a vendor that is not part of these pre-approved networks, reimbursement will be provided for medically necessary goods or services but only up to seventy (70) percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the non-network vendor's usual, customary and reasonable charge or fee or (3) the allowable contract rate pursuant to any PPO contract.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payment (if applicable)
2. Insured Deductible
3. Insured Co-payment

PPO NETWORKS – These networks include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. The Nurse Case Manager can provide the **Insured/Eligible Injured Person** with a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the **Insured/ Eligible Injured Person**. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving a list of recommended providers from which they may select that they may select from. A penalty co-payment will not be applied if you choose to select a health care provider outside of the available preferred provider networks.

DECISION POINT REVIEW PLAN PROCESS

The requirements for precertification only apply after the tenth (10) day following the automobile accident causing the injury. For every claim that is reported by the **Insured/ Eligible Injured Person**, a loss report is created and transmitted electronically to GEICO's claim office. A claim representative contacts the **Insured/Eligible Injured Person**, confirms coverage and reviews policy requirements. During this conversation, the claim representative explains decision point review and that precertification is required for the services, treatments and procedures outlined in Exhibit A. Our vendor, AIS, Inc, will provide assistance as the **Insured/Eligible Injured Person** proceeds through their course of treatment.

The **Insured/Eligible Injured Person** is provided with the toll free number to call with any questions they may have regarding the decision point review and precertification process. GEICO then transfers the loss information to AIS, Inc promptly in order to begin the precertification process.
Business days is defined as Monday through Friday 9:00 am to 5:30 pm EST/EDT, excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency. AIS, Inc can be reached at 877-308-6599.

The AIS, Inc Customer Service Call Center Staff is available twenty-four (24) hours a day for the Insured/Eligible Injured Person or his designee if represented, and their health care provider, to call with any questions pertaining to the medical expense payment portion of the claim. The Customer Service Call Center Staff can be reached at 877-308-6599. During telephone consultations with a Nurse Case Manager an attempt is made by AIS, Inc to:

- Establish a detailed account of the injury without duplicating the information electronically transferred by GEICO
- Identify health care providers currently active on the case
- Provide educational assistance in regard to the Decision Point Review Plan / Precertification

Each person will have a Nurse Case Manager assigned to his/her case who can answer medical or billing questions pertaining to the claim. For all other questions concerning their claim, the **Insured/Eligible Injured Person** should contact their claim representative. After this initial consultation, if the **Insured/Eligible Injured Person** or treating health care provider calls with a question about an existing New Jersey PIP claim as it pertains to medical expense benefits, a telephone prompt within the toll free number voicemail system 877-308-6599 offers them the option to be connected directly with the Nurse Case Manager at AIS, Inc:

During the initial telephone consultation, the **Insured and/or Eligible Injured Person** is also advised of the GEICO's designated providers for diagnostic tests; MRI, CT, CAT Scan, Somatosensory Evoked Potential (SSEP), Visual Evoked Potential (VEP), Brain Audio Evoked Potential (BAEP), Brain Evoked Potential (BEP), Nerve Condition Velocity (NCV), and H-Reflex Study, Electroencephalogram (EEG), Needle Electromyography (Needle EMG) and durable medical equipment and/or prescription medication costing more than fifty dollars ($50.00). An exception from the network requirement applies for any of the electro-diagnostic tests performed in N.J.A.C. 11:3-4.5b1-3 when done in conjunction with a needle EMG performed by the treating health care provider. The designated providers are approved through a Workers Compensation Managed Care Organization.
The designated providers are as follows:

The Atlantic Imaging Group - Diagnostic and Neuro Diagnostic testing (888)-340-5850
Optum – Durable Medical Equipment and Prescriptions (800-777-3574)

DIAGNOSTIC TESTING – Atlantic Imaging Group (Atlantic) is a provider based organization that arranges for the provisions of Diagnostic Radiology Services through access to a panel of preferred providers. Atlantic is a full-service management services organization that provides network access, credentialing, compliance, utilization review and quality assurance. Currently there are 170 participants in the State of New Jersey.

DURABLE MEDICAL EQUIPMENT – Optum offers a full service program including arrangements for fittings, delivery, set-up and training. Its national network has over 4,500 providers of which157 are in New Jersey. The Nurse Case Manager assists in this process by obtaining a prescription from the treating provider who notes specific items needed to aid the **Insured and/or Eligible Injured Person** in recovery. The Nurse Case Manager makes referrals to the DME vendor electronically. If equipment is rented, the Nurse Case Manager follows the treatment plan to determine when the **Insured and/or Eligible Injured Person** will no longer medically require the equipment. When no longer medically required, the supplying vendor will be notified to pick up the equipment.

PRESCRIPTIONS- Optum offers multiple paths for prescription drug needs. There is access to a network of over 63,000 pharmacies nationwide of which 1,939 are in New Jersey. Their website offers a pharmacy locator service utilizing a city, state and zip code search or can also be reached via telephone. The Nurse Case Manager makes referrals to the prescription vendor electronically. The **Insured and/or Eligible Injured Person** may also call a toll free customer service help desk to find participating pharmacies in their geographic area. Mail order is also available.

PPO NETWORKS – These networks include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. The Nurse Case Manager can provide the **Insured and/or Eligible Injured Person** with a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the **Insured and/or Eligible Injured Person** . The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving a list of recommended providers from which they may select that they may select from.

Each of the above vendors has a toll free number and web site access where they can be reached. The vendors have accessibility throughout the State. The Nurse Case Manager can provide this information as requested.

All bills for medical services will be sent to GEICO, P.O. Box 9515 Fredericksburg, VA 22403, or by fax to 516-213-1484. For any questions regarding billing, the provider will call GEICO at 800-301-1390 and discuss the bill with the assigned PIP adjuster OR Track the medical claim submitted to GEICO by enrolling in our online Medical Provider Claim Tracking website at: https://partners.geico.com/mpctweb.

All bills for medical services rendered will be transmitted from GEICO to AIS, Inc. The bills will be scanned into the document management system and entered into the Bill Review system. The bills will be processed for payment if they match treatment authorized as indicated in the system. If any information differs, including diagnosis, CPT coding and services rendered, the bills will be referred to the Nurse Case Manager for utilization review.

Any bills for services recommended as medically necessary by utilization review will be processed for payment and sent to **GEICO** for any applicable deductible and/or co-payments. A denial by a Nurse Case Manager would warrant referral to a Physician Advisor for medical necessity review. The results of the Physician Advisor's decision will be noted on the Explanation of Benefits. In addition, any issue related to bill payment, bill processing, Decision Point Review Request or Precertification request may be submitted to the Internal Appeal Process, prior to filing a formal dispute.

Internal Appeals 3-Level Review Process

1. First Level/The Clinical Review - The title of the person performing first level clinical reviews is the Nurse Case Manager. The State of New Jersey Board of Nursing licenses all persons in the Nurse Case Manager position as either a Registered Nurse or Licensed Practical Nurse.

In the first level of review, the Nurse Case Manager will review all diagnosis codes, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), DSM IV codes, or HCPCS codes against the treatment and testing recommendations.

Medical documentation will be reviewed on an ongoing basis. Required medical documentation from the treating provider must include documented results of the initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests. All previously performed tests that relate to the injury and their subsequent results must be submitted in writing.

Anticipated discharge will be reviewed to verify the established treatment date. If discharge has been extended and/or an additional request for services has been made, any additional medical information needed to complete the review will be requested within two (2) business days. If the Nurse Case Manager approves the requests, the system will be documented. Precertification authorization letters will be sent to Eligible Injured Person/Provider and attorney if noted on file the next business day. The Nurse Case Manager may request additional documentation when the attending provider's submitted documentation is illegible. If the Nurse Case Manager cannot render a decision that results in certification of the services requested, based on the documentation requested and submitted by the attending provider, the file will be routed to a Physician Advisor to review for medical necessity. The Physician Advisor will perform a Healthcare Provider Review/ Second Level Clinical Review.

2. Healthcare Provider Review/ Second Level Clinical Review - Healthcare Provider Review/ Second Level Clinical Review are conducted only by healthcare providers (As defined in N.J.A.C. 11:3-4.2) who hold a current non-restricted license to practice medicine or other healthcare professions in the state of New Jersey and are currently in active practice in New Jersey.

The Nurse Case Managers who review cases where documentation is considered to be complete, are required to refer any case that does not meet the clinical criteria to certify a treatment request to a Physician Advisor for review. The attending provider is notified of this at the time of intake. The Nurse Case Manager electronically submits a case information sheet to the Physician Advisor for assessment and medical determination. If additional documentation including: initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications, and physical tests are available, this is also submitted for review.

The Physician Advisor may:

a. Recommend that the clinical documentation submitted by the attending provider support the treatment request as medically necessary.

b. Recommend that the clinical documentation submitted by the attending provider does not support the treatment request as medically necessary and render an adverse determination

c. Recommend that the clinical documentation submitted by the attending provider supports a modified treatment/partial certification request as medically necessary

The Physician Advisor may make an attempt to contact the attending physician prior to making his/her recommendation. Should the Physician Advisor render an adverse decision, the appropriate adverse decision notifications are processed and directed to the health care provider, insured/ eligible injured person and attorney, if applicable.

The Physician Advisor will complete the Healthcare Provider Review/ Second Level Clinical Review. If services are recommended as medically necessary, the Utilization Review/Bill Review System will be documented and letters to the insured/eligible injured person, treating health care provider and attorney if applicable, and will be sent the next business day. If services are recommended as not medically necessary the provider will be notified of the right to appeal the decision. A letter confirming the decision will be sent to the provider with an attachment describing the appeal process.

Internal Appeals Process

Pre-Service Appeal

Each issue shall be required to receive an internal appeal review by the insurer prior to making a request for Alternative Dispute Resolution.

A pre-service appeal is an appeal of decision point review and/or precertification denials or modification prior to performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment and prescriptions. In order to be considered a valid pre-service appeal all the requirements listed below must be met:

1. AIS, Inc must be notified within thirty (30) calendar days after receipt of the written denial or modification of requested services.
2. An appeal must be communicated to an AIS Nurse Case Manager in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request.
3. The appeal must be submitted on the New Jersey PIP Pre-Service Appeal Form and all fields 1-34 must be completed in order to be considered. If either the New Jersey PIP Pre-Service Appeal Form is not submitted or if any fields on the New Jersey PIP Pre-Service Appeal Form are not completed then the Appeal will be administratively denied. In addition, the original APTP form, APTP decision/response document, and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Pre-Service Appeal Form or the Pre-Service Appeal may be administratively denied.
4. Appeals must be submitted to Auto Injury Solutions, Inc. **P.O. Box 1247, Daphne, AL 36526 or faxed to 866-257-2323.**
5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured person, must make and complete an internal appeal prior to making a request for dispute resolution.
6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.
7. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests must be made as a Pre-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Pre-Service Appeal no later than fourteen (14) calendar days after receipt of the New Jersey PIP Pre-Service Appeal Form and any supporting documentation.

Post-Service Appeal

A Post-Service Appeal is an appeal made subsequent to the performance or issuance of the services.

In order to be considered a valid post-service appeal, all the requirements listed below must be met:

1. A post-service appeal shall be submitted to the AIS, Inc in writing within ninety (90) calendar days of the issuance of the decision that is being appealed and at least forty five (45) calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or any other litigation against us. If a post-service appeal form is submitted outside of this period of time then it will be invalid and will not be considered.

2. The appeal must be submitted on the New Jersey PIP Post-Service Appeal Form and all fields 1-38 shall be completed. If either the New Jersey PIP Post-Service Appeal Form is not submitted or the fields are not completed then the Appeal will be administratively denied. In addition, the original bill (HCFA/UB), explanation of benefit/payment (EOB), and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Post-Service Appeal Form or the Post-Service Appeal may be administratively denied.

3. An appeal must be communicated in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the billed services shall not be accepted as an appeal request.

4. Appeals must be submitted to AUTO INJURY SOLUTIONS, **P.O. Box 1247, Daphne, AL 36526 or faxed to 866-257-2323.**

5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured party must make and complete an internal appeal prior to making a request for dispute resolution.

6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.

7. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests cannot be made as a Post-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Post-Service appeal no later than thirty (30) calendar days after receipt of the New Jersey PIP Post Service Appeal Form and any supporting documentation.

Any dispute which has not been submitted to the appeal process shall not be a valid part of any arbitration or litigation. Proof of a timely-filed appeal is required documentation when an Alternate Dispute Resolution demand is made.

A Standard Healthcare Provider Clinical Review Appeal (Third Level Review) will be conducted within fourteen (14) calendar days.

The Physician Advisor is available through AIS, Inc via the Nurse Case Manager by telephone at 877-308-6599 during regular business days. Business days is defined as Monday through Friday 9:00 am to 5:30 pm EST/EDT, excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency.

3. Healthcare Provider Clinical Review Appeal (Third Level Review): Healthcare Provider Clinical Review Appeal (Third Level Review) clinical reviews are conducted only by healthcare providers (as defined in N.J.A.C. 11:3-4.2) who hold a current non-restricted licenses to practice medicine or other healthcare professions in the state of New Jersey and are currently in active practice in New Jersey. The physicians who perform the medical reviews at this level will also be credentialed and certified in accordance with the requirements of the State of New Jersey. A provider filing an appeal only has thirty (30) calendar days from the date he/she is notified of the adverse decision. If an appeal is not submitted as required in the Pre-Service Appeal and Post-Service Appeal sections of this Plan, it will not be considered. A Pre-Service appeal must be communicated on a New Jersey PIP Pre-Service Appeal Form by facsimile or mailing address in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request. A Post-Service appeal must be communicated on a New Jersey PIP Post-Service Appeal Form and submitted to AUTO INJURY SOLUTIONS, P.O. Box 1247, Daphne, AL 36526 or faxed to 866-257-2323, with supporting documentation and reasons for the appeal.

Should a physician review be necessary, a specialist will be selected to perform this appeal who is medically qualified by certification, practice and training to deal specifically with the clinical issue under review.

Under GEICO's Conditional Assignment of Benefits conditions, a provider who has accepted an assignment of benefits is required to utilize the Internal Appeals Process for these issues, prior to filing a demand for dispute resolution.

ASSIGNMENT OF BENEFITS

Assignment of an Insured's/Eligible Injured Person's rights to receive benefits for medically necessary treatment, durable medical equipment tests or other services is prohibited except to licensed health care providers who must agree to:

a. Fully Comply with GEICO's Decision Point Review Plan, including Precertification requirements,
b. Comply with the terms and conditions of GEICO's Family Automobile Insurance Policy,
c Provide complete and legible medical records or other pertinent information when requested by us,
d. Complete the "Internal Appeals Process" which shall be a condition precedent to the filing of a demand for Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification requests. Completion of the internal appeal process means timely submission of an appeal, receipt of the response, and completion of the expiration of the forty five (45) day waiting period for post-service appeals, prior to filing for alternate dispute resolution. Except for emergency care as defined in N.JA.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

e. Submit disputes to Dispute Resolution pursuant to N.J.A.C. 11:3-5,

f. Submit to statements and/or Examinations Under Oath as often as deemed reasonable and necessary.

Failure by the health care provider to comply with all the foregoing requirements will render any Assignment of Benefits null and void. Should the health care provider accept direct payment of benefits, the health care provider is required to hold harmless the Insured/Eligible Injured Person and GEICO for any reduction of payment for services caused by the health care provider's failure to comply with the terms of the Insured's policy and this Plan. Should the assignee choose to retain an attorney to handle the Internal Appeals Process, they do so at their own expense.

GEICO's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that GEICO has the right to reject, terminate or revoke the GEICO conditional Assignment of Benefits. An assignment of benefits may require GEICO's written consent.

DISPUTE RESOLUTION

If there is a dispute as to any issue arising under this Decision Point Review/Precertification Plan, or in connection with any claim for Personal Injury Protection benefits, a request for the resolution of that dispute may be made by the Insured/Eligible Injured Person, GEICO, or a treating health care provider who has a valid Assignment of Benefits from the Insured or Insured/Eligible Injured Person. The request for dispute resolution may also include a request by any of these parties for review by a Medical Review Organization.

If we, GEICO, and/or any person seeking Personal Injury Protection benefits, do not agree as to the recovery of such benefits, or with any decision made or arising pursuant to this Decision Point Review/Precertification Plan, then the matter is required to be heard and can only be resolved by a dispute resolution organization pursuant to New Jersey law rather than filed in the Superior Court of New Jersey. A health care provider is required to have fully complied with all aspects of this Decision Point Review/Precertification Plan, including but not limited to having fully complied with the Internal Appeal Process, prior to filing any claim or action in dispute resolution.

EXHIBIT A

a. 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
b. Non-emergency surgical procedures performed in a hospital, freestanding surgical center, hospital outpatient surgical facility, office, etc., and any provider services associated with the surgical procedure.
c. Extended care rehabilitation facilities
d. Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths
e. Physical, occupational, speech, cognitive, rehabilitation or other restorative therapy or therapeutic or body part manipulation including manipulation under anesthesia except that provided for Identified Injuries in accordance with Decision Point Review
f. Non-emergency inpatient and outpatient psychological/psychiatric services/treatment and testing including biofeedback
g. All pain management services except as provided for Identified Injuries in accordance with Decision Point Review
h. Home health care
i. Non-Emergency Dental Restorations
j. Temporomandibular disorder; any oral facial syndrome
k. Infusion therapy
l. Bone scans
m. Vax-D/DRX type devices
n. Acupuncture
o. Durable medical equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of fifty (50) dollars or rental in excess of thirty (30) calendar days
p. Brain Mapping other than provided under Decision Point Review
q. Transportation services costing more than fifty (50) dollars
r. Prescription medication costing more than fifty (50) dollars
s. Any procedure that uses an unspecified CPT; CDT; /DSM IV; HCPCS code
t. Computerized Muscle Testing
u. CAT Scan with Myelogram
v. Discogram
w. Current perceptual testing
x. Temperature gradient studies
y. Work hardening
z. Carpal Tunnel Syndrome
aa. Podiatry
bb. Audiology
cc. Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a monthly rental or rental in excess of thirty (30) calendar 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. Spa/gym memberships
    h. Recreational activities and trips
    i. Leisure activities and trips
    j Nutritional services

GEICO
PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS
(For losses occurring on or after 10/1/12)

Policy Number: _____ **Claim Number:** _____

Patient's Name: _____ **Provider's Name:** _____

I authorize and request Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company, GEICO Casualty Company collectively referred to as "GEICO" to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ _____
Patient's Signature or Parent/Legal Guardian Date

I have read the information contained in the GEICO informational letter concerning the Decision Point Review Plan, Decision Point Review and Precertification requirements (collectively, " **Plan**") and, as a condition precedent to GEICO's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have fully complied and will comply with all the requirements of the **Plan**.
2. I (We) have complied and will comply with the terms and conditions of the GEICO Family Automobile Insurance Policy.
3. I (We) will initiate all Precertification review and Decision Point Review requests as required by the **Plan**.
4. I (We) will submit disputes as defined in the **Plan** to the Internal Dispute Resolution process set forth therein. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
5. I (We) will submit all disputes not subject to the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
6. I (We) will submit complete and legible medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
7. I (We) will comply with a request to (i) submit to an examination under oath, and (ii) provide GEICO with any other pertinent information/documentation that it requests.
8. In the event that I (we) fail to comply with paragraphs one (1) though (7) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. I (we) shall be entitled to pursue payment from the patient when benefits are not payable due to a violation of a policy condition by the patient and/or when benefits are not payable due to lack of coverage.

I (we) agree that this assignment is the only valid Assignment of Benefits. I (we) agree that this Assignment of Benefits may require GEICO's written consent. I (we) agree that GEICO has the right to reject, terminate or revoke this Assignment of Benefits.

_____ Date: _____
Provider's Signature

_____ TIN Number: _____
Provider's Name (Please Print)

Provider's Address: _____
_____
_____

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." N.J.S. 17:33A-6.
This form is accessible at www.GEICO.com
http://www.geico.com/information/states/nj/personal-injury-protection/

{LETTERHEAD}

INITIAL INFORMATION LETTER TO INSURED/ELIGIBLE INJURED PERSON/PROVIDERS
Sent on Auto Injury Solution and GEICO's Letter Head

Date:
Claim Number:
Doctor/Patient Name:
Injured Person Name:
Address Line 1:
Address Line 2:
Address Line 3:

Dear Provider/Patient:

Please read this letter carefully because it provides specific information concerning how a medical claim under Personal Injury Protection coverage will be handled, including specific requirements which you must follow in order to ensure payment for medically necessary treatment, tests, durable medical equipment and/or prescription medication that an Insured/Eligible Injured Person may incur as a result of a covered automobile accident.

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

GEICO requires that the Insured/Eligible Injured Person advise and inform them about the injury and the claim as soon as possible after the accident and periodically thereafter. This may include the production of information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. If this information is not supplied as required, GEICO shall impose an additional co-payment as a penalty which shall be no greater than:

a) Twenty five (25) percent when received thirty (30) or more calendar days after the accident; or b) Fifty (50) percent when received sixty (60) or more calendar days after the accident.

FOR LOSSES OCCURRING ON OR AFTER OCTOBER 1, 2012
Auto Injury Solutions (AIS), Inc has been selected by GEICO to implement their Plan. AIS, Inc will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Re-pricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

Mailing Instructions:

All Decision Point Review, Pre-certification and Internal Appeals related documents are to be submitted to :

Auto Injury Solutions (AIS), Inc.

PO Box 1247 Daphne, AL 36526

Phone Number: 877-308-6599

Fax Number: 866-257-2323

All Other mail is to be submitted to:

GEICO

P.O. Box 9515 Fredericksburg, VA 22403

Fax Number: 516-213-1484

DECISION POINT REVIEW

The New Jersey Department of Banking and Insurance has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the **Identified Injuries**. The **Care Paths** provide that treatment be evaluated at certain intervals called **Decision Points**. On the **Care Paths**, Decision Points are represented by hexagonal boxes. At Decision Points the Insured/Eligible Injured Person or treating health care provider must provide us information about further treatment that is intended to be provided.

This is called a **Decision Point Review**.

In addition, the administration of any diagnostic tests set forth in N.J.A.C. 11:3-4.5(b) is subject to **Decision Point Review** regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or by calling AUTO INJURY SOLUTIONS (AIS), Inc at 877-308-6599. The Decision Point Review Plan and Informational Letter to the Insured/ Eligible Injured Person/Providers are accessible by accessible on GEICO's website at: http://www.geico.com/information/states/nj/personal-injury-protection/ *(scroll down to Losses Occurring On or After October 1,2012).*

The **Decision Point Review** requirements do not apply to treatment or diagnostic tests administered in an emergency situation and/or during the first (10) calendar days after the insured accident causing the injury; however, only medically necessary treatment related to the motor vehicle accident will be reimbursed.

AIS Nurse Case Managers are available during regular business days. Business days is defined as Monday through Friday 9:00am to 5:30pm EST/EDT, excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency. All requests for pre-authorization received outside of regular business days will be considered to have been received on the next business day. The AIS Customer Service Call Center Staff is available twenty-four (24) hours a day for the Insured/Eligible Injured Person or his designee if represented, and their health care provider, to call with any questions pertaining to the medical expense payment portion of the claim.

If the treating health care provider considers certain diagnostic testing to be medically necessary and causally related to the insured accident causing the injury, this also requires **Decision Point Review** per N.J.A.C. 11:3-4, regardless of diagnosis. The **Insured/Eligible Injured Person** or treating health care provider must notify us by supplying legible written support establishing the need for the test before we can consider authorizing it. The list of diagnostic tests requiring prior authorization and a list of diagnostic tests which the law prohibits us from authorizing under any circumstances are shown below. If the **Insured/Eligible Injured Person** or treating health care provider fails to properly submit diagnostic testing requests for **Decision Point Review** or fails to properly submit clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested, payment of your bills may be subject to a penalty co-payment of fifty (50) percent, even if the services are later determined to be medically necessary and causally related to the insured accident causing the injury.

The following is a list of specific diagnostic tests subject to Decision Point Review:

- Brain Mapping
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Computer Assisted Tomographic Studies (CT, CAT Scan)
- Dynatron/Cybex Station/Cybex Studies; and any range of muscle motion testing
- Video-fluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography (needle EMG)
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Magnetic Resonance Imaging (MRI)

- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Thermogram/Thermography
- Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation
- All diagnostic test identified in NJAC 11:3-4.5(b) for identified and all other injuries

These diagnostic tests must be administered in accordance with New Jersey Department of Banking and Insurance regulations which set forth the requirements for the use of diagnostic tests in the evaluation of injuries sustained in an auto accident.

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. 11:3-4.5:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation
- Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Person Injury Protection coverage

MANDATORY PRECERTIFICATION

If the Insured/Eligible Injured Person does not have an Identified Injury, we require that the Insured/Eligible Injured Person or their health care provider request Precertification for the services, treatments and procedures which includes, but is not limited to: diagnostic test(s), durable medical equipment, prescription medication, or otherwise potentially covered medical expense benefits. The Insured/Eligible Injured Person or their health care provider must request Precertification by providing us with reasonable prior notice of the anticipated services, treatments and procedures as outlined above, as well as the appropriate clinically supported findings to facilitate timely approval. When appropriate, the health care provider may submit a comprehensive treatment plan for Precertification.

Precertification will not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury; however, only medically necessary treatment and/or testing which is related to the motor vehicle accident will be reimbursed. The following treatments, services and/or conditions, goods and non-medical expenses require precertification:

a. 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

b. Non-emergency surgical procedures performed in a hospital, freestanding surgical center, hospital outpatient surgical facility, office, etc., and any provider services associated with the surgical procedure.

c. Extended care rehabilitation facilities

d. Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths

e. Physical, occupational, speech, cognitive, rehabilitation or other restorative therapy or therapeutic or body part manipulation including manipulation under anesthesia except that provided for Identified Injuries in accordance with Decision Point Review

f. Non-emergency inpatient and outpatient psychological/psychiatric services/treatment and testing including biofeedback

g. All pain management services except as provided for Identified Injuries in accordance with Decision Point Review

h. Home health care

i. Non-emergency dental restorations

j. Temporomandibular disorder; any oral facial syndrome

k. Infusion therapy

l. Bone scans

m. Vax-D/DRX type devices

n. Acupuncture

o. Durable medical equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of fifty (50) dollars or rental in excess of thirty (30) calendar days

p. Brain Mapping other than provided under Decision Point Review

q. Transportation services costing more than fifty (50) dollars

r. Prescription medication costing more than fifty (50) dollars

s. Any procedure that uses an unspecified CPT; CDT; /DSM IV; HCPCS code

t. Computerized muscle testing

u. CAT Scan with Myelogram

v. Discogram

w. Current perceptual testing

x. Temperature gradient studies

y. Work hardening

z. Carpal tunnel syndrome

aa. Podiatry

bb. Audiology

cc. Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a monthly rental or rental in excess of thirty (30) calendar 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. Spa/gym memberships

h. Recreational activities and trips

i. Leisure activities and trips

j. Nutritional services

If your provider fails to request Decision Point Review / Precertification where required or fails to provide clinical findings that support the treatment, testing or durable medical equipment requested a copayment penalty of 50% will apply even if the services are determined to be medically necessary. For benefits to be reimbursed in full, treatment, testing and durable medical equipment must be medically necessary.

VOLUNTARY PRECERTIFICATION

Health care providers are encouraged to participate in a Voluntary Precertification process by providing AIS, Inc. with a **comprehensive treatment plan** for both identified and other injuries.

Concentra Integrated Services, Inc. will utilize nationally accepted criteria and the Care Paths to work with the health care provider to certify mutually agreeable course of treatment to include itemized services and defined treatment periods

In consideration for the health care provider's participation in the voluntary certification process, the bills that are submitted, when consistent with the precertified services will be paid as long as they are in accordance with the PIP medical fee schedules set forth in N.J.A.C. 11.3-29.6. Having an approved comprehensive treatment plan means that as long as treatment is consistent with the agreed upon comprehensive treatment plan, additional notification to AIS, Inc at Decision Points and for treatment, diagnostic testing, or durable medical equipment requiring Precertification is not required.

THE SUBMISSION OF DECISION POINT REVIEW, MANDATORY PRECERTIFICATION AND/OR VOLUNTARY PRECERTIFICATION REQUESTS

We will review properly submitted requests for treatment and/or testing within three (3) business days after we receive them. Proof of receipt by AIS, Inc must be provided by the submitting party at the insurer's request. A Decision Point Review and/or Mandatory or Voluntary Precertification requests is necessary for us to determine whether additional treatment or administration of a test is medically necessary. In order for us to make this determination the treating health care provider or the Insured/Eligible Injured Person must provide us with reasonable prior notice, as set forth herein, by submitting a completed Attending Provider Treatment Plan (APTP) form together with appropriate legible and clinically supported findings A copy of the APTP form can be found on the New Jersey Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or on GEICO's website at http://www.geico.com/information/states/nj/personal-injury-portection/

A properly submitted APTP form must be completed in its entirety and faxed directly to AIS, Inc at 866-257-2323. It must include the Insured/Eligible Injured Person's full name and birth date, the claim number, the date of the accident, diagnoses/ICD-9 codes or ICD-10 codes, each CPT code requested including frequency, duration, signature of the requesting physician and date of signature.

Additionally, properly submitted requests for Decision Point Review and Precertification must include legible, clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. Clinically supported findings supplied to AIS, Inc must not only be legible but also establish that a health care provider, prior to selecting, performing or ordering the administration of a treatment, diagnostic testing or durable medical equipment, has:

- Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or durable medical equipment;
- Physically examined the patient, including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications and physical tests;
- Considered the results of any and all previously performed tests that related to the injury and which are relevant to the proposed treatment, diagnostic testing or durable medical equipment; and
- Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

We will review a fully completed and properly submitted request for treatment and/or testing within three (3) business days after receiving the request. Following our review, we have the option to:

a. Recommend authorization of reimbursement for the treatment, test, durable medical equipment and/or prescription medication; or

b. Recommend denial of reimbursement for the treatment, test, durable medical equipment, prescription medication where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity; or

c. Recommend modification/partial certification of reimbursement for the treatment, test, durable medical equipment, prescription medication where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity for the treatment plan requested; or

d. Request additional documentation from the attending providers when the submitted documentation is illegible; or

e. Schedule a mental or physical examination of the Insured/Eligible Injured Person where the notice and supporting materials are insufficient to authorize, deny, or modify reimbursement or further treatment, test, durable medical equipment or prescription medication; or

f. Advise you that the Decision Point Review/Precertification request cannot be processed as the request is incomplete due to the lack of, or an incomplete, APTP which is mandated to be submitted with every Decision Point Review/Precertification request as per New Jersey Department of Banking and Insurance on the State mandated form. A submitted APTP is considered to be incomplete if it lacks information that is vital to determine medical necessity. A submitted APTP must be signed by the treating health care provider of the proper specialty and dated.

Our approval of requests for treatment and/or testing will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, the medical protocols adopted in N.J.A.C. 11:3-4 recognized by the Commissioner of Banking and Insurance. Our final determination of medical necessity of any treatment and/or testing shall be made by a physician or dentist as appropriate for the injury and treatment contemplated.

When an improperly submitted and/or incomplete request is received, AIS, Inc will inform the treating health care provider of what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation will be issued and will remain in effect until all requested information needed to properly process a review to determine medical necessity regarding the requested treatment, diagnostic testing and/or durable medical equipment is received. Our determination will be provided within three (3) business days following receipt of the additional required documentation or information. If we fail to notify the Insured/Eligible Injured Person or treating health care provider of our determination within three (3) business days following receipt of the additional required documentation or information, you may continue with the test or treatment until our final determination is communicated to your treating health care provider. However, only medically necessary treatment related to the motor vehicle accident will be reimbursed.

Approved treatment, diagnostic testing and durable medical equipment is only approved for the range of dates noted in the determination letter. If the Insured/Eligible Injured Person and/or treating health care provider fail to follow the Decision Point Review/Precertification procedures identified in this document, any approved treatment, diagnostic testing and/or durable medical equipment completed and/or requested after the authorization period (last date in the range of dates indicated in the authorization notice letter) expires will be subject to a penalty co-payment of fifty (50) percent, even if the services are determined to be medically necessary.

INDEPENDENT MEDICAL EXAMINATIONS (IME)

If we request a Physical or Mental Examination:

a. The appointment will be scheduled within seven (7) calendar days of our receipt of the notice of additional treatment or tests, unless the Insured/Eligible Injured Person agrees to extend the time period;

b. The mental or physical examination will be conducted by a provider in the same discipline as the treating provider;

c. The examination will be conducted at a location reasonably convenient to the Insured/Eligible Injured Person. If unable to attend the examination, the Eligible Injured Person must notify AIS, Inc at 1-888-701-5692 at least three (3) business days before the examination date.

- Failure of the Insured/Eligible Injured Person to attend a scheduled IME without proper notice to AIS , Inc shall constitute an unexcused failure to attend a scheduled IME. The burden is on the Insured/Eligible Injured Person to prove that proper notice was provided.
- Failure of an Insured/Eligible Injured Person to attend a scheduled IME will be considered excused if the Insured/Eligible Injured Person notifies AIS, Inc at least three (3) business days prior to the IME date and reschedules the IME for a date, not to exceed thirty-five (35) calendar days from the date of the original IME.

d. The Insured/Eligible Injured Person must, if requested, provide medical records, diagnostic imaging films, test results and other pertinent information to the examining provider conducting the examination. In addition, the Insured/Eligible Injured Person may be requested to bring prescribed electro-stimulation devices and/or supports/braces to the examination. The requested records and/or items must be provided no later than the time of the examination. Failure to comply with this requirement will result in an unexcused failure to attend the IME.

e. The Insured/Eligible Injured Person must supply proper identification at the examination. A photo ID is required. Failure to supply the proper identification may constitute an incomplete IME until the proper documents are obtained. If the Insured/Eligible Injured Person is non-English speaking, then an English speaking interpreter must accompany the Insured/Eligible Injured Person to the IME. No interpreter fees or costs will be compensable. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

f. Examinations will be scheduled to occur within thirty-five (35) calendar days of receipt of the request for additional treatment/test or service.

- If an Insured/Eligible Injured Person has an excused failure to attend a scheduled IME and does not reschedule the IME within thirty-five (35) calendar days of the original IME date, the failure to attend the original IME will be unexcused.

The Insured/Eligible Injured Person must attend IMEs scheduled to occur beyond thirty-five (35) calendar days of receipt of the request for additional treatment/test or service in question, must be attended. Failure to attend an IME scheduled to occur more than thirty-five (35) calendar days after receipt of the request will be considered an unexcused absence.

g. If the Insured/Eligible Injured Person has two or more unexcused failures to attend a scheduled examination of the same specialty, notification will be sent to the Insured/Eligible Injured Person, his designee if noted, and all health care providers providing treatment for the diagnosis (and related diagnoses) contained in the APTP form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment and/or prescription medication required for the diagnosis (and related diagnoses) contained in the APTP form will not be reimbursable as a consequence of failure to comply with the Plan. Except for surgery, procedures performed in ambulatory surgical centers, and invasive dental procedures, treatment that is medically, necessary and related to injuries from the motor vehicle accident in question, may proceed while the examination is being scheduled and until the results become available. However, only medically necessary treatment related to the motor vehicle accident will be reimbursed. If the examining provider prepares a written report concerning the examination, the Insured/Eligible Injured Person, or his designee, shall be entitled to a copy of the report upon request.

Examples of the injured person's unexcused failures to attend the examination may include but are not limited to one of the following:

- Failure to provide the medical records and/or diagnostic films before or on the day of examination;
- Failure to reschedule the examination with three (3) or more business days;
- Failure to present valid photo identification or any form of identification at the time of the examination;
- Failure to be accompanied by an English interpreter if the Insured/Eligible Injured Party is non- English speaking;
- Failure to attend an examination scheduled to occur beyond thirty-five (35) calendar days of the receipt of the request of additional treatment/test or service in question;
- Failure to cooperate fully with the examining physician.

We will attempt to notify the health care provider and the Insured/Eligible Injured Person, or his designee, of our decision to recommend authorization or denial of reimbursement for the treatment or test as promptly as possible, but no later than three (3) business days following the examination. Any recommendation of denial for reimbursement of further treatment / tests or service will be based on the determination of a physician or dentist.

VOLUNTARY NETWORKS

AIS , Inc has established networks of pre-approved vendors that can be recommended for the provision of certain services, diagnostic tests, durable medical equipment and/or prescription medication. Insured/Eligible Injured persons are encouraged, but not required, to obtain certain services, diagnostic tests, durable medical equipment and/or prescription medication from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy and any applicable fee schedules. If they use a vendor that is not part of these pre-approved networks, reimbursement will be provided for medically necessary, causally related and reasonable goods or services but only up to seventy (70) percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29.4, or (2) the non-network vendor's usual, customary and reasonable charge or fee. The Networks can be assessed either through a referral from the Nurse Case Manager (877-308-6599) or by contacting:

The Atlantic Imaging Group 888-340-5850 - for Diagnostic and Neuro Diagnostic

Optum 800-777-3574 - for Durable Medical Equipment and Prescriptions

The plan includes voluntary networks for:

- MRI
- CAT Scan
- Somatosensory Evoked Potential (SSEP)
- Visual Evoked Potential (VEP)
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Nerve Condition Velocity (NCV)
- H-Reflex Study
- Electroencephalogram (EEG)
- Needle Electromyography (Needle EMG)
- Video-fluoroscopy durable medical equipment and/or prescription medication costing more than fifty dollars ($50)

- An exception from the network requirement applies for any of the electro-diagnostic tests performed in N.J.A.C. 11:3-4.5(b) 1-3 when done in conjunction with the needle EMG performed by the treating health care provider. The designated providers are approved through Worker's Compensation Managed Care Organization.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payments (If applicable)
2. Insured Deductible
3. Insured Co-payment

PPO NETWORKS

These networks include health care providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. Upon request, the Nurse Case Manager can provide the Insured/Eligible Injured Person with a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the Insured/Eligible Injured Person. The PPO networks are provided as a service to the Insured/ Eligible Injured Person. A penalty co-payment will not be applied if you choose to select a health care provider outside of the available preferred provider networks.

PENALTY/CO-PAYMENTS AND THE DECISION POINT REVIEW PROCESS

If a request for Decision Point Review or Precertification is not submitted as required, or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty (50) percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment under the Personal Injury Protection coverage.

If you do not utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section set forth above, payment for those services rendered will result in a co-payment of thirty (30) percent (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, diagnostic tests and durable medical equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy. Any penalty reduction shall be applied prior to any other deductible or co-payment requirement.

The additional co-payment of fifty (50) percent for failure to pre-certify treatment will not apply if we have received the required notice, supporting medical documentation, and have failed to respond within three (3) business days to authorize or deny reimbursement of further treatment or tests. Our failure to respond within three (3) business days will allow a health care provider to continue treatment until we provide the required notice.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payments (If applicable)
2. Insured Deductible
3. Insured Co-payment

ASSIGNMENT OF BENEFITS

Assignment of an Insured's/ Eligible Injured Person's rights to receive benefits for medically necessary treatment, durable medical equipment, tests or other services is prohibited except to licensed health care providers who must agree to:

a. Fully Comply with GEICO's Decision Point Review Plan, including Precertification requirements,
b. Comply with the terms and conditions of GEICO's Family Automobile Insurance Policy,

c. Provide complete and legible medical records or other pertinent information when requested by us,

d. Complete the "Internal Appeals Process" which shall be a condition precedent to the filing of a demand for Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification requests. Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.JA.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

e. Submit disputes to Dispute Resolution pursuant to N.J.A.C. 11:3-5,

f. Submit to statements and/or Examinations Under Oath as often as deemed reasonable and necessary.

Failure by the health care provider to comply with all the foregoing requirements will render any Assignment of Benefits null and void. Should the health care provider accept direct payment of benefits, the health care provider is required to hold harmless the Insured/ Eligible Injured Person and GEICO for any reduction of payment for services caused by the health care provider's failure to comply with the terms of the Insured's policy and this Plan. Should the assignee choose to retain an attorney to handle the Internal Appeals Process, they do so at their own expense. **GEICO's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that GEICO has the right to reject, terminate or revoke the GEICO conditional Assignment of Benefits. An assignment of benefits may require GEICO's written consent.**

INTERNAL APPEAL PROCESS

"Services" is defined as performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment.

Pre-service Appeals:

A pre-service appeal is an appeal of a decision point review and/or precertification denial or modification prior to performance or issuance of the requested medical procedure, treatment, diagnostic test, or other service, and/or durable medical equipment and prescriptions.

If a health care provider disagrees with our determination related to Decision Point Review or Precertification of services, then the health care provider must submit a completed New Jersey PIP Pre-Service Appeal form for reconsideration of the decision. Medical necessity appeals of denial of Decision Point Review or Precertification requests must only be made as a Pre-Service Appeal. The appeal must be submitted on the New Jersey PIP Pre-Service Appeal form and all fields 1-34 must be completed in order to be considered. If either the New Jersey PIP Pre-Service Appeal form is not submitted or if any fields on the New Jersey PIP Pre-Service Appeal form are not completed then the Appeal will be administratively denied. In addition, the original APTP form, APTP decision/response document, and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Pre-Service Appeal form or the Pre-Service Appeal may be administratively denied.

To access the Internal Appeals Process, you must submit to AIS, Inc a completed New Jersey PIP Pre-Service Appeal form, with all relevant supporting documentation, no later than thirty (30) calendar days after receipt of the written denial or modification of the requested services. The New Jersey PIP Pre-Service Appeal form can be obtained at: http://www.geico.com/information/states/nj/personal-injury-protection/ *(scroll down to Losses Occurring On or After October 1, 2012).*

All pre-service appeals for reconsideration of a Decision Point Review or Precertification medical determination must include not only the basis for the appeal but also the medical criteria to support the dispute of a medical determination. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as a valid pre-service appeal request. A completed New Jersey PIP Pre-Service Appeal form must be submitted and responded to by the carrier prior to completion of the requested services that are the subject of the appeal. If a New Jersey PIP Pre-Service Appeal form is not submitted within thirty (30) calendar days after receipt of denial or modification of the requested services then the appeal is not valid and will not be considered. A pre-service appeal must be properly filed in accordance with the terms of the DPR Plan prior to the filing of any action against GEICO relating to any pre-service issue or decision made by GEICO and the filing of a pre-service appeal shall be a condition precedent to the filing of any action against GEICO.

Consistent with the terms of the Decision Point Review plan and the Assignment of Benefits provision, a health care provider proceeding under an Assignment of Benefits must utilize the Internal Appeals Process which shall be a condition precedent to the filing of a demand of Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review or Precertification request. Performance of medical services prior to submitting a Pre-Service Appeal will invalidate the appeal and the healthcare provider's Assignment of Benefit. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

All New Jersey PIP Pre-Service Appeal forms must be submitted in writing to AIS, Inc via certified mail/return receipt requested or via courier that provides proof of delivery to AIS, Inc within thirty (30) calendar days from the date of the adverse determination to: AUTO INJURY SOLUTIONS, Inc. P.O. Box 1247, Daphne, AL 36526; or via fax to 866-257-2323. Proof of receipt by AIS, Inc must be provided by the disputing party at GEICO's request.

A decision on the Pre-service appeal will be completed and communicated to the provider who submitted the appeal within fourteen (14) calendar days of receipt of the properly submitted and completed New Jersey PIP Pre-Service Appeal form and receipt of any supporting documentation we may request.

Post-Service Appeals:

A Post-Service Appeal is an appeal made subsequent to the performance or issuance of the services.

The treating healthcare provider may request a post-service appeal on issues not related to a request for Decision Point Review or Precertification. These issues may include, but are not limited to, bill review or payment for services. Medical necessity appeals of denial of Decision Point Review or Precertification requests cannot be made as a post -service appeal. A post-service appeal must be properly filed in accordance with the terms of the DPR Plan prior to the filing of any action against GEICO relating to any post-service issue or decision made by GEICO and the filing of a post-service appeal shall be a condition precedent to the filing of any action against GEICO. A New Jersey PIP Post-Service Appeal form shall be submitted to the AIS, Inc in writing within ninety (90) calendar days of the issuance of the decision that is being appealed and at least forty five (45) calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or any other litigation against us. If a New Jersey PIP Post-Service Appeal form is submitted outside of this period of time then it will be invalid and will not be considered. The appeal must be submitted on the New Jersey PIP Post-Service Appeal Form and all fields 1-38 shall be completed. If either the New Jersey PIP Post-Service Appeal Form is not submitted or the fields

are not completed then the Appeal will be administratively denied. In addition, the original bill (HCFA/UB), explanation of benefit/payment (EOB), and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Post-Service Appeal Form or the Post-Service Appeal may be administratively denied.

The New Jersey PIP Post-Service Appeal form can be obtained at http://www.geico.com/information/states/nj/personal-injury-protection/ *(scroll down to Losses Occurring On or After October 1, 2012)*. The completed New Jersey PIP Post-Service Appeal form must be signed by the treating healthcare provider and must include supporting documentation and reasons for the post-service appeal. A decision on the post-service appeal will be completed no later than thirty (30) calendar days after receipt of the New Jersey PIP Post-Service Appeal form and all supporting documentation. Post-service appeals must be submitted only to AUTO INJURY SOLUTIONS, P.O. Box 1247, Daphne, AL 36526, or faxed to 866-257-2323.

Consistent with the terms of the Decision Point Review plan and the Assignment of Benefits provision, a health care provider proceeding under an Assignment of Benefits must utilize the Internal Appeals Process which shall be a condition precedent to the filing of a demand of Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review or Precertification request. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Ambulatory Surgery Centers (ASCs) and any health care provider as defined and listed under NJAC 11:3-4.2, shall utilize the Pre-Service Internal Appeals Process.

If the Insured/Eligible Injured Person and/or health care provider retains counsel to represent them during the appeal process, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal process shall be compensable.

DISPUTE RESOLUTION

If there is a dispute as to any issue arising under this Decision Point Review/Precertification Plan, or in connection with any claim for Personal Injury Protection benefits, a request for the resolution of that dispute may be made by the Insured/Eligible Injured Person, GEICO, or a treating health care provider who has a valid Assignment of Benefits from the Insured or Insured/Eligible Injured Person. The request for dispute resolution may also include a request by any of these parties for review by a Medical Review Organization.

If we, GEICO, and/or any person seeking Personal Injury Protection benefits, do not agree as to the recovery of such benefits, or with any decision made or arising pursuant to this Decision Point Review/Precertification Plan, then the matter is required to be heard and can only be resolved by a dispute resolution organization pursuant to New Jersey law rather than filed in the Superior Court of New Jersey. A health care provider is required to have fully complied with all aspects of this Decision Point Review/Precertification Plan, including but not limited to having fully complied with the Internal Appeal Process, prior to filing any claim or action in dispute resolution.

Sincerely,

,Examiner Code
1-800-841-3000 Ext.
Claims Department

GEICO
PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS
(For losses occurring on or after 10/1/12)

Policy Number: _____ **Claim Number:** _____
Patient's Name: _____ **Provider's Name:** _____

I authorize and request Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company, GEICO Casualty Company collectively referred to as "GEICO" to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ _____
Patient's Signature or Parent/Legal Guardian Date

I have read the information contained in the GEICO informational letter concerning the Decision Point Review Plan, Decision Point Review and Precertification requirements (collectively," **Plan**") and, as a condition precedent to GEICO's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have fully complied and will comply with all the requirements of the **Plan**.
2. I (We) have complied and will comply with the terms and conditions of the GEICO Family Automobile Insurance Policy.
3. I (We) will initiate all Precertification review and Decision Point Review requests as required by the**Plan**.
4. I (We) will submit disputes as defined in the **Plan** to the Internal Appeals Process set forth therein. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
5. I (We) will submit all disputes not subject to the Internal Appeals Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
6. I (We) will submit complete and legible medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
7. I (We) will comply with a request to (i) submit to an examination under oath, and (ii) provide GEICO with any other pertinent information/documentation that it requests.
8. In the event that I (we) fail to comply with paragraphs one (1) though (7) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. I(we) shall be entitled to pursue payment from the patient, when benefits are not payable due to a violation of a policy condition by the patient and/or when benefits are not payable due to lack of coverage.

I (we) agree that this assignment is the only valid Assignment of Benefits. I (we) agree that this Assignment of Benefits may require GEICO's written consent. I (we) agree that GEICO has the right to reject, terminate or revoke this Assignment of Benefits.

_____ _____
Provider's Signature Date:

_____ _____
Provider's Name (Please Print) TIN Number:

Provider's Address: _____

_____

_____

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." N.J.S. 17:33A-6.
This form is accessible at
www.geico.com/information/states/nj/personal-injury-protection/

EXHIBIT 6

PO Box 907
Lincroft, NJ 07738

Plymouth Rock Management Company of New Jersey
High Point Preferred Insurance Company
High Point Safety and Insurance Company
High Point Property and Casualty Insurance Company
Teachers Auto Insurance Company of New Jersey
Palisades Safety and Insurance Association
Palisades Insurance Company
Palisades Property and Casualty Insurance Company

SUPPLEMENTAL SURGICAL PRE-CERTIFICATION REQUEST
(NON-EMERGENCY PROCEDURES)

Physician Name: _____ Physician's Telephone Number: _____
Fax Number: _____ Request Date: _____

Please complete all the fields below
Documentation to support the need for and causal relationship of surgery must be submitted including MRI, CT scans, Discogram, EMG and most recent office notes with the request for pre-certification.

Patients Name:	Claim Number:
Date of Loss:	Proposed Surgery Date:
CPT Code(s) / Procedure(s) :	
ICD-9 Diagnostic Code(s):	
Surgical Procedure Description:	
Name of Facility, Hospital or Ambulatory Surgical Center where the surgical procedure will be performed:	

Please check the applicable box:

☐ I do not anticipate requiring an assistant surgeon or co-surgeon.

☐ I propose using a co-surgeon/assistant surgeon/physician assistant/Registered Nurse First Assistant (circle the one that applies)
Name: _____

☐ I propose using two or more surgeons. Name(s): _____

Responsibility(ies): _____

☐ Post-operative care beyond those included within the global fee package (required)
(Specify type of care/services [example – post operative physical therapy (including duration / and frequency, Durable Medical Equipment, etc.]) _____

☐ Inpatient admission required. ☐ Same day Surgery

REQUESTS FOR CO-SURGEONS AND ASSISTANT SURGEONS MUST MEET CMS GUIDELINES

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 **www.cms.gov**

More Than Just Insurance.
Plymouth Rock assurance

PO Box 900
Lincroft, NJ 07738

Plymouth Rock Management Company of New Jersey
High Point Preferred Insurance Company
High Point Safety and Insurance Company
High Point Property and Casualty Insurance Company
Teachers Auto Insurance Company of New Jersey
Palisades Safety and Insurance Association
Palisades Insurance Company
Palisades Property and Casualty Insurance Company

April 5, 2017

JOSEPH A MASSOOD ESQUIRE
50 PACKANACK LAKE RD
WAYNE NJ 07470-5834

We have revised our Decision Point Review Plan for the High Point, Palisades, Teachers and Twin Lights group of insurers effective as of 4/17/2017. **This revised plan applies to all claims, both new and existing, as of that date.**

PRA NJ 203 04/17 replaces the existing Decision Point Review Plan.

A summary of updates is being sent to all existing claimants. A copy of the new Decision Point Review Plan is being provided to all new claimants upon notification of claim. Should you wish to obtain a copy of the new Decision Point Review Plan, you can call us at (800) 258-1476, or visit our website at PlymouthRockNJ.com.

Please note that changes have been made to the following sections:

1. Added a **HIPAA Compliant Medical Authorization**

2. **Addition of an Information Production Penalty -** This would be applied to the injured party when information pertinent to their claim handling has not been provided timely. This is included in 11:3-4.4(f)(2)

3. **Pre-certification Requirements**
   a. Decreased $100 limit on Durable Medical Equipment to $50 to be consistent with the regulation
   b. Prescription Medication - Added a statement to indicate that while there is no pre-certification requirement for prescribed medication, it can be reviewed for medical necessity and/or causal relationship. This is not a new process.

4. **Voluntary Networks**
   a. Diagnostic Testing Network - Added in an explanation that results and reports are required for specific electrodiagnostic testing as stated by the governing bodies for these tests
   b. Durable Medical Equipment - We decreased $100 limit on Durable Medical Equipment to $50 to be consistent with the regulation
   c. Outpatient Facility Services - Clarified position of which procedures are covered

5. **Submission of Attending Provider Treatment Plan**

a. Added a statement to indicate that we will only accept this form from the provider or prescriber of services, treatment, etc. who personally examine the patient
b. Adding a requirement for the requesting party to identify their specialty
c. Added the requirement that when treatment is being requested by a Physician's Assistant or Nurse Practitioner, that the specialty of their supervising physician is identified
d. For surgical procedures a provider must also include a "Surgical Pre-Cert Form"
e. We removed the 60 day extension of time for a provider to complete their services and replaced it with the time specified in our letter responding to the Decision Point Review/Pre-certification Request
f. Additional changes were made to be consistent with the regulation

6. **Physical Examinations**
   a. Amended to indicate that when requested the claimant should bring their medical records to the exam and all prescribed durable medical equipment. Failure to comply with the request and submission of information will result in an unexcused failure to attend the Independent Medical Examination
   b. Added the requirement for the claimant to notify the carrier of the need for an interpreter within 10 business days of the scheduled exam

7. **Standardized Appeal Process** was added
   a. Pre-Service Appeals need to be faxed to 732-978-7100
   b. Post-Service Appeals need to be faxed to 732-978-6320

8. References to ICD9 codes have been modified to generically state 'ICD codes'

If you have any questions regarding this letter or the changes to our Decision Point Review Plan, we encourage you to contact Customer Care at (800) 437-5556. A Customer Care Specialist will be glad to help.

Sincerely,

Louis Palomeque
Vice President of Claims

Plymouth Rock Assurance takes an active role against insurance fraud, but we need your help. If you know or suspect someone is committing insurance fraud, let us know. Contact our anonymous Fraud hotline at **1-855-FRAUDNJ**.