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September 1, 2017

PIP ALERT

ATTN: **Medical Providers/Billing Companies**
From: **Joseph A. Massood, Esq.**
Re: **Allstate's revised DPRP**
PATIENT MAY CONTINUE TO TREAT

Allstate has revised their Decision Point Review Plan. The medical provider's assignment will no longer be voided if the patient continues to treat during the appeals process.

Although Allstate's revised DPRP still contains language on Page 5 that a patient must delay surgery pending the IME exam, the language voiding the Assignment of Benefits has been removed and the patient should therefore not have to delay treatment pending an IME.

Pre-service Appeals are required to be filed within 30 calendar days from the date of the denial.

Post-service Appeals are required to be filed at least 45 calendar days prior to initiating arbitration or filing an action in the Superior Court.

PRE-CERTIFICATION REQUESTS AND ALL APPEALS (PRE-SERVICE AND POST-SERVICE) MUST BE SUBMITTED TO OPTUM BY ONE OF THESE THREE METHODS:

1) VIA FAX TO 610-631-7094
2) BY WEB http://providerhub.procuranet.com; or
3) BY EMAIL AIMSAdmin@optum.com.

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

ALLSTATE NEW JERSEY INSURANCE COMPANY / ALLSTATE NEW JERSEY PROPERTY AND CASUALTY INSURANCE COMPANY

DECISION POINT REVIEW PLAN INCLUSIVE OF PRECERTIFICATION REQUIREMENT

Pursuant to the Automobile Insurance Cost Reduction Act (AICRA), signed into law on May 19, 1998, the New Jersey Legislature has enacted certain controls that affect automobile insurance coverage, in order to address medically necessary treatments, diagnostic testing, and the use of durable medical equipment.

As a result of AICRA, and in accordance with the terms of the Allstate New Jersey Insurance Company and Allstate New Jersey Property and Casualty Insurance Company's (ANJIC/ANJP&C) automobile insurance policy which includes the terms of the following Decision Point Review Plan (DPRP), the Eligible Insured and Treating Health Care Provider(s) have certain obligations that must be satisfied in order for ANJIC/ANJP&C to potentially provide coverage for medically necessary and causally related treatments, diagnostic testing, and the use of durable medical equipment, after an automobile accident in which the Eligible Insured(s) are injured.

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

Treatments obtained in an emergency situation and / or within ten days of the insured event are not subject to decision point review *(represented by the hexagonal symbols on the Care Paths)* / precertification requirements. This provision shall not be construed so as to require reimbursement of tests and treatment that are not medically necessary, N.J.A.C. 11:3-4.7(b).

The *Care Paths* provide that treatment be evaluated at certain intervals called *Decision Points*. At *decision points*, you or your health care provider must provide Optum Managed Care Services (Optum) information about further treatment the provider intends to pursue. This is called *Decision Point Review*. The Care Paths and accompanying rules are available on the Internet on the Department of Banking and Insurance website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or by calling Optum at 877-722-8037.

This DPRP has been approved by the Commissioner of Banking and Insurance and has been formulated in accordance with N.J.A.C. 11:3-4.7. Failure to fully comply with the terms of this DPRP may affect coverage for medically necessary and causally related treatments, diagnostic testing, and the use of durable medical equipment.

Eligible Insured's Obligations

- Fully comply with the terms of the ANJIC/ANJP&C's automobile insurance policy, including the following DPRP, as well as all applicable laws, rules, regulations, statutes and guidelines.

For every claim that is reported by the Eligible Insured, a loss report is created and transmitted electronically to ANJIC/ANJP&C's claim office. An ANJIC/ANJP&C claim representative contacts the Eligible Insured, confirms coverage and reviews the policy requirements. During this conversation, the ANJIC/ANJP&C claim representative explains precertification is required for other injuries, services, treatments and procedures. The Eligible Insured is sent a letter confirming receipt of the claim and given an explanation of the benefits and processes.

Optum will advise the Eligible Insured of the Care Path requirements upon notification to ANJIC/ANJP&C of a claim filed under Personal Injury Protection and send a copy of the Decision Point Review Plan to the Eligible Insured and attorney, if represented. Upon notification from a Treating Health Care Provider that they are administering health care services to the Eligible Insured on a claim, Optum will send a copy of the Decision Point Review Plan to that Treating Health Care Provider.

In these Decision Point Review and Precertification Process documents, treating Health care providers are furnished with Optum's toll free telephone number and fax number for providing Decision Point Review notice, Mandatory Precertification notice and/or Voluntary Precertification notice. Upon receipt of a Decision Point Review/Precertification notice by a treating health care provider, Optum will review the documentation submitted. If the services that are being requested are found to be clinically supported and medically necessary and causally related, Optum shall notify both the Treating Health Care Provider and the Eligible Insured by fax and/or written notice of the determination in accordance with N.J.A.C. 11:3-4.7.

DECISION POINT REVIEW:

If your health care provider considers certain diagnostic testing to be medically necessary, this also requires ***Decision Point Review*** per N.J.A.C. 11:3-4, regardless of diagnosis. You or your 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 prior authorization and a list of diagnostic tests which the law prohibits us from authorizing under any circumstances are shown below. If you or your health care provider fail to submit diagnostic testing requests for ***Decision Point Review*** or fail to 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 50%, even if the services are later determined to be medically necessary.

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

- Brain Mapping
- Brain Audio Evoked Potentials (BAEP)
- Brain Evoked Potentials (BEP)
- Computer Assisted Tomograms (CT, CAT Scan)
- Dynatron/cybex station/cybex studies
- Videofluoroscopy
- 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

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:

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

PRECERTIFICATION:

For treatment, diagnostic testing or durable medical equipment not included in the care paths or subject to ***Decision Point Review,*** you or your health care provider are required to obtain our precertification for the following services and/or conditions listed below. If you or your providers fail to pre-certify such services, or fail to provide clinically supported findings that support the medical necessity of the treatment, services and/or condition, diagnostic tests or DURABLE MEDICAL EQUIPMENT requested, payment of bills will be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary. The following treatments, services and/or conditions, goods and non-medical expenses require pre-certification:

- Non-Emergency Inpatient and Outpatient Care including the facility where the services will be rendered and any provider services associated with these services and/or care.
- Non-emergency surgical procedures, performed in a hospital, freestanding surgical center, office, etc., and any provider services associated with the surgical procedure.
- Non-Emergency inpatient and outpatient Psychological/Psychiatric Services
- Outpatient care for soft tissue/disc injuries of the injured party's, neck, back and related structures not included within the diagnoses covered by the Care Path

- Extended Care and Rehabilitation Facilities
- All Home Health Care
- Computerized muscle testing
- Cat Scan w/Myelogram
- PENs/PNT
- Skilled Nursing / Rehabilitation Services
- Trigger Point Dry Needling
- Compound Drugs
- Drug Screening
- Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;
- Discogram
- Infusion Therapy
- Current perceptual testing;
- Temperature gradient studies;
- Work hardening;
- Carpal Tunnel Syndrome;
- Vax-D / DRX types devices ;
- Podiatry;
- Audiology;
- Bone Scans.
- Non-Emergency Dental Restoration
- Prescriptions costing more than $50.00;
- Treatment, testing and/or durable medical goods of Temporomandibular disorders and/or any oral facial syndrome
- Transportation Services costing more than $50.00;
- Any procedure that uses an unspecified CPT; CDT; DSM IV; HCPCS codes.
- Durable Medical Goods, including orthotics and prosthetics that collectively exceed $50.00 cost and/or monthly rental greater than 30 days.
- Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a cost of $50.00 and/or monthly rental greater than 30 days, including but not limited to:

    1. vehicles
    2. modification to vehicles
    3. durable goods
    4. furnishings
    5. improvements or modifications to real or personal property
    6. fixtures
    7. recreational activities and trips
    8. leisure activities and trips
    9. spa/gym membership

- Physical, Occupational, Speech, Cognitive, or other restorative therapy or Body part manipulation, including massage therapy, except that provided for Identified Injuries in accordance with ***Decision Point Review.***
- All Pain Management services, except as provided for Identified Injuries in accordance with ***Decision Point Review,*** including but not limited to:

    1. acupuncture
    2. nerve blocks
    3. manipulation under anesthesia
    4. anesthesia when performed in conjunction with invasive techniques
    5. radio frequency/rhyzotomy
    6. narcotics, when prescribed for more than 3 months
    7. biofeedback
    8. implantation of spinal stimulators or spinal pumps
    9. trigger point injections
    10. tens units (transcutaneous electrical nerve stimulation)
    11. PENs/PNT

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:

You and your health care provider are encouraged to participate in a Voluntary Precertification process by providing a comprehensive treatment plan for both identified and other injuries to Optum. An approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification to Optum at ***Decision Points*** and for Treatment, Diagnostic Testing or Durable Medical Equipment requiring ***precertification*** is not required.

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

ANJIC/ANJP&C may require that the insured 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, ANJIC/ANJP&C may impose an additional co-payment penalty which shall be no greater than:

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

HOW TO SUBMIT DECISION POINT and/or PRECERTIFICATION REQUESTS:

Decision Point / Precertification requests must be submitted directly to Optum and should be submitted by fax to at 610-631-7094.

You may also submit your requests to Optum via the web: http://providerhub.procuranet.com or at the following e-mail address: AIMSAdmin@optum.com.

Optum shall provide 24 hour, 7-day / week telephone service. Regular business hours are Monday through Friday 7:30 AM to 5:00 PM Eastern Time. All requests for pre-authorization on weekends and Federal and/or NJ State Holidays will be handled on the next business day.

Properly Submitted Requests

Pursuant to N.J.A.C. 11:3-4.7(d), all providers must use the Attending Provider Treatment Plan (APTP) form, to submit ***Decision Point Review and Precertification*** Requests. No other forms for this purpose are permitted. A copy of the APTP form is available at http://www.nj.gov/dobi/aicrapg.htm or by contacting Optum at 877-722-8037, or at www.procura-inc.com.

A properly submitted APTP form must be completed in its entirety. It must include the injured person's full name and birth date, the claim number, the date of the accident, diagnoses / ICD-9 code(s) or ICD-10 code(s), each CPT code requested including frequency, duration and signature of the requesting healthcare provider.

Properly submitted requests for ***decision point review and precertification*** must also include legible clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. Clinically supported findings, supplied to Optum, 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:

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.

Within three business days following receipt of a properly submitted request, Optum will provide its determination. Our failure to respond within three business days will allow a provider to continue treatment until we provide the required notice.

When an improperly submitted request is received, Optum will inform your treating 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 needed to properly process a review to determine medical necessity regarding the requested treatment/testing and/or durable medical equipment is received. Our determination will be provided within three business days following receipt of the additional required documentation or information. If we fail to notify the eligible injured party or provider of our determination within 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 provider.

Any denial of treatment or testing based on medical necessity shall be made by a physician or dentist.

PLEASE NOTE: Authorized testing, treatment and/or durable medical equipment is only approved for the range of dates noted in the determination letter(s). If you intend to perform authorized services beyond the approved range of dates, you must resubmit the request in accordance with the Properly Submitted Request section above.

Expired Authorization:

If you or your treating Provider fails to follow the decision point review/precertification procedures identified in this document, any approved testing, treatment and/or durable medical equipment completed 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-pay of 50%, even if the services are determined to be medically necessary.

INDEPENDENT MEDICAL EXAMINATION

Optum or the insurance carrier may request that you attend an Independent Medical Examination. If an Independent Medical Examination is requested, the appointment for the physical examination will be scheduled within 7 calendar days of receipt of the notice, unless the injured person agrees with Optum to extend the time period.

The Independent Medical Examination will be conducted by a provider in the same specialty of your treating provider and will be conducted in a location reasonably convenient to the eligible injured person.

Results of the Independent Medical Examination and the determination regarding your provider's request will be submitted to you in writing and to your health care provider in writing and by telephone within 3 business days after the examination. Except for non-emergent tests, surgery, procedures performed in ambulatory surgical centers, and invasive dental procedures, treatment 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 eligible injured person, or his or her designee, shall be entitled to a copy of the report upon request.

Examination will be scheduled to occur within 30 calendar days of the receipt of the request. Examinations scheduled to occur beyond 30 calendar days of the receipt of the request, must be attended. Failure to attend an examination scheduled to occur more than thirty (30) calendar days after receipt of the request will be considered an unexcused failure to attend the examination.

You are required to present photo identification, or any form of identification, to the examining provider at the time of the exam. Failure to comply with this requirement will result in an unexcused failure to attend 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. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

If you must reschedule your appointment, you must contact Optum at 877-722-8037 no less than three (3) business days prior to the scheduled appointment. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

You must provide all medical records and diagnostic studies/tests available before or at the time of the examination. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the IME. If the injured person has 2 or more unexcused failures to attend the scheduled exam notification will be immediately sent to the injured person, or to his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the injured person on notice that all further treatment, diagnostic testing or durable medical equipment required for the diagnosis, (and related diagnosis) contained in the Attending Provider Treatment Plan form, will not be reimbursable as a consequence for failure to comply with the plan.

An example of the 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 and/or diagnostic films before or on the day of examination;
- To reschedule the examination it must be done with 3 or more business days notice;
- 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 eligible injured party is non-English speaking;
- Failure to present for any of the examination appointments for any reason.
- Failure to attend an examination scheduled to occur beyond 30 calendar days of the receipt of the request of additional treatment/test or service in question.

VOLUNTARY UTILIZATION NETWORK (VUN) PROGRAM (Waiver of Penalty Copayment):

Optum has a provider network that is available to you. As outlined in N.J.A.C. 11:3-4.8, the Optum Network is an approved network as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6. The benefits of the network include ease of access, credentialed and quality providers and the fact that your penalty copayment is waived when accessing a network provider.

In accordance with N.J.A.C. 11:3-4.8 the plan includes a voluntary network for:

1. Magnetic Resonance Imaging (MRI)
2. Computer Assisted Tomography (CT/CAT Scans)
3. Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests *
4. Somatosensory Evoked Potential (SSEP)
5. Visual Evoked Potential (VEP)
6. Brain Audio Evoked Potential (BAEP)
7. Brain Evoked Potential (BEP)
8. Nerve Conduction Velocity (NCV)
9. H reflex Study
10. Electroencephalogram (EEG)
11. Durable Medical Equipment with a cost or monthly rental in excess of $50.
12. Prescription Drugs
13. Services, equipment or accommodations provided by an ambulatory surgery facility.

* except when performed together by the treating physician.

When any of the services listed above is authorized at any point in the **decision point review** or **precertification** or appeal process, information about accessing our voluntary network of providers is available on the websites or at the toll free numbers listed below. Those individuals who choose not to utilize the network will be assessed a penalty copayment not to exceed 30% of the eligible charge, including if the treatment is denied but subsequently approved. That penalty copayment will be the responsibility of the eligible injured party.

There are two specific Networks for the below specified services:

A. Prescription Drugs:
Cypress Care at 800-419-7191 or at www.cypresscare.com.

B. Diagnostic Imaging/Electrodiagnostic Testing:
Information regarding the Optum provider network is available to you at www.procura-inc.com or by calling at 877-722-8037.

C. Durable Medical Equipment:
Information regarding the Optum provider network is available to you at www.procura- inc.com or by calling at 877-722-8037.

D. Services, equipment or accommodations provided by an ambulatory surgery facility.
Information regarding the Optum provider network is available to you at www.procura-inc.com or by calling at 877-722-8037.

Information regarding our provider network is available to you at www.procura-inc.com or by calling at 877-722-8037. Our provider network includes Optum providers as well as the Magnacare Network.

PREFERRED PROVIDER ORGANIZATION (PPO)

In addition, Optum makes available a Preferred Provider Organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. The use of a provider from our PPO is strictly voluntary and is provided as a service to you. A penalty copayment will not be applied if you choose to select a provider outside this preferred provider network. Preferred providers have facilities located throughout the state. Information regarding our PPO network is available to you at www.procura-inc.com or by calling Optum at 877-722-8037. Our PPO Network includes Optum providers as well as the Magnacare Network.

PENALTY

As outlined in N.J.A.C. 11:3-4.4 (d), failure to request ***Decision Point Review or Precertification*** as required in our ***Decision Point Review / Precertification*** plan will result in a 50% penalty copayment. This co-payment penalty will be in addition to any co-payment stated in the schedule of your policy. Failure to submit clinically supported findings that support your ***decision point review or precertification*** request will result in a 50% copayment penalty. Failure to use an approved network provider for Prescription Drugs, Diagnostic Imaging/Electro diagnostic Testing, Durable Medical Equipment, and services, equipment or accommodations provided by an ambulatory surgery facility will result in a 30% penalty copayment. All penalty copayments will be applied before the application of the policy copayment and deductible.

ASSIGNMENT OF BENEFITS

Assignment of a named insured's or eligible injured person's rights to receive benefits for medically necessary treatment, durable medical equipment tests or other services is prohibited except to a licensed health care provider who agrees to:

(a) Fully comply with ANJIC/ANJP&C Decision Point Review Plan, including precertification requirements,
(b) Comply with the terms and conditions of the ANJIC/ANJP&C 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 alternative dispute resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification request. Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution.
(e) Submit disputes to alternative dispute resolution pursuant to N.J.A.C. 11:3-5
(f) Submit to statements or examinations under oath as often as deemed reasonable and necessary.

As a further condition to the Assignment of Benefits, the licensed provider agrees to consent to the consolidation of all pending arbitrations involving the same person, accident, or claim number.

Failure by the health care provider to comply with all the foregoing requirements will render any prior assignment of benefits under ANJIC/ANJP&C policy null and void. Should the provider accept direct payment of benefits, the provider is required to hold harmless the insured and ANJIC/ANJP&C for any reduction of payment for services caused by the provider's failure to comply with the terms of the insured's policy.

INTERNAL APPEAL PROCESS

General Terms: As a condition precedent to filing an arbitration or litigation, a provider of service benefits who has accepted an assignment must submit a written request to appeal any and all disputes, including but not limited to any claims for unpaid medical bills for medical 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. Any medical provider that has accepted an assignment of benefits must comply with the Internal Appeals Process prior to initiating arbitration or litigation. Pursuant to N.J.A.C. 11:3-5.1, any completed appeal may be submitted to Alternate Dispute Resolution. If the injured party 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. To the extent permitted by law, the results of said Alternate Dispute Resolution processes shall be final and binding.

All appeals must include the appeal form established by the Department by order in accordance with N.J.A.C. 11:3-4.7B(c), along with all supporting documentation. Any submission received from a medical provider without the appeal forms required by N.J.A.C. 11:3-4.7B(c) and/or supporting documentation shall not be considered as an appeal.

The pre and post service appeal forms must be completed including, but not limited to the minimum required fields as indicated by asterisk (*). Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with these requirements will result in an administrative denial of the appeal.

All appeals must be submitted in writing to Optum via fax to 610-631-7094, email at AIMSAdmin@optum.com or via the web at: http://providerhub.procuranet.com. Any appeal not sent via the aforementioned fax, email or web address must be submitted via certified mail/return receipt requested or via courier that provides proof of delivery to Optum. Proof of receipt by the insurer must be provided by the disputing party at the insurer's request.

Pursuant to N.J.A.C. 11:3-4.7B(b), each issue shall only be required to receive one internal appeal review, by the insurer prior to making a request for alternate dispute resolution.

Pre-service Appeals: If a healthcare provider disagrees with a determination related to decision point review and/or precertification of any medical procedure, treatment, diagnostic test, other service or dispensing of any durable medical equipment, prescription or other items, that healthcare provider shall submit a pre-service appeal for reconsideration of that decision in accordance with the guidelines set forth in N.J.A.C. 11:3-4.7B. All pre-service appeals shall be submitted no later than 30 calendar days from the medical provider's receipt of the adverse determination and shall include the basis for the appeal along with the medical criteria to support the dispute of that medical determination. Failure to comply with these requirements will result in an administrative denial of the appeal.

Submission of information identical to the initial material submitted in support of the request shall not be accepted as a request for appeal. The injured party, and/or health care providers, may be requested to submit additional documentation in order to complete the internal review. If so, the deadline for the pre-service appeal response will toll until such requested documentation is received by Optum.

An Optum Medical Director will be available to consult with the health care provider during the pre-service appeal process. If it is determined that peer review or an Independent Medical Examination is appropriate, this information will be communicated within 14 calendar days of receipt of the pre-service appeal. A final decision for pre-service appeals will be communicated the injured party and health care provider within 14 calendar days of receipt of the pre-service appeal form and supporting documentation. Consistent with the terms of the decision point review plan and the assignment of benefits provision, a provider who proceeds under an assignment of benefits must utilize the pre-service appeal process which shall be a condition precedent to filing of a demand for arbitration for any issue related to medical necessity.

Post-service Appeals: If a health care provider disagrees with a determination related to the payment of any medical procedure, treatment, diagnostic test, other service or dispensing of any durable medical equipment, prescription or other items, that healthcare provider shall submit a post-service appeal for reconsideration of that decision in accordance with the guidelines set forth in N.J.A.C. 11:3-4.7B. All post-service appeals shall be submitted at least 45 calendar days prior to initiating dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in the Superior Court. Post-service appeals shall include all new supporting documents necessary to evaluate and reconsider payment. Failure to comply with this requirement will result in an administrative denial of the appeal. The injured party, and/or health care providers, may be requested to submit additional documentation in order to complete the internal review. If so, the deadline for the post-service appeal response will toll until such requested documentation is received by Optum. All post-service appeals involving UCR disputes, must be accompanied by UCR proofs from the requesting health care provider. All post-service appeals involving PPO disputes, must be accompanied by any information which the health care provider intends to prove or rebut the application of the subject PPO agreement and/or rates. All post-service appeals involving Health Insurance Carrier/PIP Secondary disputes, must be accompanied by Health Insurance carrier EOBs/ proofs from the requesting health care provider.

A final decision for post-service appeals will be communicated to the injured party and health care provider within 30 calendar days of receipt of the post-service appeal form and supporting documentation. Consistent with the terms of the

decision point review plan and the assignment of benefits provision, a provider who proceeds under an assignment of benefits must utilize the post-service appeal process which shall be a condition precedent to filing of a demand for arbitration for any issue related to bill payment.

EXHIBIT A

Identified Injuries

The following **International Classification of Diseases, 9th** Revision Clinical Modification - fifth edition **ICD-9-CM** diagnostic codes are associated with Care Path 1 through Care Path 6 for treatment of Accidental Injury to the Spine and Back and are included on each appropriate Care Path. The ICD9 codes referenced do not include codes for multiple diagnoses or co-morbidity.

Care Path 1
728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions - not elsewhere classified
739.1 Somatic dysfunction of cervical region
847.0 Sprains and strains of neck
847.9 Sprains and strains of back, unspecified site
922.3 Contusion of back
922.31 Contusion of back, excludes interscapular region
953.0 Injury to cervical root

Care Path 2
722.0 Displacement of cervical intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.71 Intervertebral disc disorder with myelopathy, cervical region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified
953.0 Injury to cervical root

Care Path 3
728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions - not elsewhere classified
739.2 Somatic dysfunction of thoracic region
739.8 Somatic dysfunction of rib cage
847.1 Sprains and strains, thoracic
847.9 Sprains and strains of back, unspecified site
922.3 Contusion of back
922.33 Contusion of back, interscapular region

Care Path 4
722.0 Displacement of cervical intervertebral disc without myelopathy
722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.11 Displacement of thoracic intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.72 Intervertebral disc disorder with myelopathy, thoracic region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified

Care Path 5
728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions - not elsewhere classified
739.3 Somatic dysfunction of lumbar region
739.4 Somatic dysfunction of sacral region
846 Sprains and strains of sacroiliac region
846.0 Sprains and strains of lumbosacral (joint) (ligament)
846.1 Sprains and strains of sacroiliac ligament
846.2 Sprains and strains of sacrospinatus (ligament)
846.3 Sprains and strains of sacrotuberous (ligament)
846.8 Sprains and strains of other specified sites of sacroiliac region

846.9 Sprains and strains, unspecified site of sacroiliac region
847.2 Sprains and strains, lumbar
847.3 Sprains and strains, sacrum
847.4 Sprains and strains, coccyx
847.9 Sprains and strains, unspecified site of back
922.3 Contusion of back
922.31 Contusion of back, excludes interscapular region
953.2 Injury to lumbar root
953.3 Injury to sacral root

Care Path 6
722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.10 Displacement of lumbar intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.73 Intervertebral disc disorder with myelopathy, lumbar region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified
953.3 Injury to sacral root