



10 Woodbridge Center Drive \* PO Box 5038 \* Woodbridge, NJ 07095

June 09, 2006

Name  
Address  
City, State Zip Code

RE: CLAIMANT:  
CLAIM#:  
INSURANCE CO: **Personal Service Insurance Company**  
DOL:

Dear :

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 prescription drugs that a named insured or eligible injured person may incur as a result of an auto accident.

**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 *Identifies Injuries*. The *Care Paths* provide that treatment be evaluated at certain intervals called *Decision Points*. At decision points, either you or the treating health care provider must provide us with information about further treatment that is intended to be provided (this is referred to as *Decision Point Review*). Such information includes reasonable prior notice and the appropriate clinically supported findings that are being relied upon to support that the anticipated treatment or test is medically necessary. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first 10 days after the accident causing the injury. The *Care Paths* and accompanying rules are available on the Internet on the Department's website at <http://www.nj.gov/dobi/aicrapg.htm> (Scroll down to PIP Reforms) or by calling Concentra Integrated Services, Inc. at (800) 818-7610 for Personal Service Insurance Company and Personal Service Insurance Company's website at [www.personalserviceinsurance.com](http://www.personalserviceinsurance.com)

In addition, the administration of certain diagnostic tests is subject to *Decision Point Review* regardless of the diagnosis. The following tests are subject to decision point review:

- Needle electromyography (needle EMG)
- Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV), and H-reflex study

- Electroencephalogram (EEG)
- Videofluoroscopy
- Magnetic resonance imaging (MRI)
- Computer assisted tomographic studies (CT, CAT scan)
- Dynatron/cyber station/cybex
- Sonograms/ultrasound
- Thermography/ thermograms
- Brain mapping
- Any other diagnostic test that is subject to the requirements of the Decision Point Review Plan by New Jersey law or regulation.

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 evaluation injuries sustained in an auto accident.

We will notify you or your treating health care provider of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days after a request has been made. A request for treatment, testing, durable medical equipment or prescription drugs is to be submitted together with legible, conspicuously presented, clinically supported findings that the proposed treatment, testing, durable medical equipment or prescription drugs is in accordance with the standards of medical necessity established under Personal Service Insurance Company's policy and New Jersey law. Any denial of reimbursement for further medical treatment or tests will be based on the determination of a physician or dentist. If we fail to take any action or fail to respond within three business days after receiving the required notification and supporting medical documentation at a decision point, then the treating health care provider is permitted to continue the course of treatment until we provide the required notice. Please note that the decision point review requirements do not apply to treatment or diagnostic tests administered during emergency care.

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

#### **Mandatory Precertification**

New Jersey Regulation provides that insurers may require precertification of certain treatments or diagnosis tests for other types of injuries or tests not included in the Care Paths. Precertification means providing us with notification of intended medical procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses. Precertification does not apply to treatment or diagnosis tests administered during emergency care or during the first ten days after the accident causing the injury.

The following are procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses for which precertification is required:

- Non-emergency inpatient and outpatient hospital care;
- Non-emergency surgical procedures;
- Extended care rehabilitation facilities;
- Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnosis covered by the Care Paths;

- Physical, Occupation, speech, cognitive or other restorative therapy or other therapeutic or body-part manipulation including manipulation under anesthesia except that provided for identified injuries in accordance with decision point review;
- Outpatient psychological/psychiatric services and testing including biofeedback;
- All pain management services except as provided for identified injuries in accordance with decision point review;
- Home health care;
- Non-emergency dental restoration;
- Temporomandibular disorder; any oral facial syndrome; Infusion Therapy;
- Bone scans;
- Vax-D
- Transportation Services costing more than \$50.00;
- Brain Mapping other than provided under Decision Point Review;
- Durable Medical Equipment including orthotics and prosthetics costing more than \$50.00;
- Prescriptions costing more than \$50.00;

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, Care Paths 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.

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

#### **Voluntary Precertification**

Health care providers are encouraged to participate in a voluntary precertification process by providing Concentra Integrated Services, 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 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 certification 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 treatment plan means as long as treatment is consistent with the plan, additional notification to Concentra Integrated Services, Inc. at decision points is not required.

#### **Voluntary Networks**

Personal Service Insurance Company's vendor, Concentra Integrated Services, Inc., has established networks of pre-approved vendors which can be recommended 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 conduction velocity (NCV), and H-reflex study, Electroencephalogram (EEG), needle electromyography (needle EMG) and durable medical equipment and prescriptions costing more than \$50.00. An exception from the

network requirement applies for any of the electro diagnostic tests performed in 11:3-4,5b1-3 when done in conjunction with a needle EMG performed by the treating provider. The designated providers are approved through a Workers Compensation Managed Care Organization.

You are encouraged, but not required, to obtain the noted service from one of the pre-approved vendors. If you use a pre-approved vendor from one of these networks for medically necessary goods or services, you will be fully reimbursed for those goods and services consistent with the terms of your auto insurance policy. If you choose to use a vendor that is not part of these pre-approved networks, we will provide reimbursement for medically necessary goods and services but only up to seventy 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 vendor's usual, customary and reasonable charge or fee. The Networks can be accessed either through a referral from the Nurse Case manager or by contacting  
The Atlantic Imaging Group - Diagnostic testing 888-340-5850  
Progressive Medical - Durable Medical Equipment and Prescriptions 800-777-3574

Concentra has PPO Networks available that include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire state. The Nurse Case Manager can provide 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 injured party. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving them recommendations of providers that they may select from. Networks include CHN Solutions and Focus NJ Chiropractic.

### **Internal Appeals Process**

If a Decision Point Review request or a request to precertify any medical treatment, tests, durable medical equipment or prescriptions drugs is denied, you are entitled to seek an appeal of such decision. To access the Internal Appeals Process you must notify CIS within 30 days of the denial. A peer to peer Standard Appeal third level review will be conducted within 5-7 business days. An Expedited Appeal can be conducted within 1-3 business days. The Nurse Case Manager determines the applicable appeal process based on medical need. Appeals should be submitted to Concentra Integrated Services, Inc., P.O. Box 5038, Woodbridge, NJ 07095 or faxed to (732) 734-2546. An appeal can also be communicated to the Nurse Care Manager via telephone. Either party can appeal to an Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5 if the issue can not be resolved through the Internal Appeals Process.

### **Reconsideration and Appeals Process**

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

For disputes on issues other than requests for decision point review and precertification,

any treating provider who has accepted an assignment of benefits must submit a written request for Reconsideration and Appeals specifying the issues in dispute accompanied by supporting documentation at least 21 days prior to initiating arbitration or litigation.

### **Dispute Resolution Process**

Any disputes not resolved in the Reconsideration and Appeals Process may be submitted through the Personal Injury Protection Dispute Resolution process which is governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the National Arbitration Forum (NAF) at 732-271-6100 or 1-800-747-2371. Information is also available on the NAF's Web site, <http://www.arb-forum.com/nj/>. Unless emergent relief is sought, failure to utilize the Reconsideration and Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

### **Assignment of Benefits**

Assignment of your rights to receive benefits for medically necessary treatment, testing, durable medical equipment or prescription drugs or other services are prohibited except to a licensed health care provider who agrees to fully comply with our Decision Point Review Plan. If the provider accepts direct payment of benefits, the provider must hold harmless the insured and/or eligible injured person for any deduction or declination in benefits caused by the provider's failure to comply with the terms of the policy and the treating provider agrees to submit disputes to Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5. The assignment is limited by statute and regulation to a licensed health care provider who complies with the restrictive language contained within the Personal Service Insurance Company's insurance policy.

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

### **Medical Examinations**

At our request, we may require a medical examination (IME) to determine medical necessity of further treatment or testing. The appointment will be made within 7 calendar days of receipt of the notice that an IME is required unless the injured person agrees to extend the time period. The IME will be completed by a provider in the same discipline as the treating provider and upon request the injured person must provide medical records and other pertinent information to the provider conducting the IME. The IME will be conducted at a location reasonably convenient to the insured and/or eligible injured party. Within three business days following the examination the injured party and provider will be notified as to whether they will be reimbursed for further treatment. The injured party or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If there are two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the Named Insured and/or Eligible Injured Person, Attorney if noted and all health care providers providing treatment for the diagnosis (and related diagnosis) contained in the attending physician's treatment

plan form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment or prescription drugs required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form will not be reimbursable as a consequence for failure to comply with the plan. Treatment may proceed while the IME is being scheduled and until the results become available.

Sincerely,

Nurse Case Manager

Telephone: (800) 818-7610 ext.

Fax: (732) 734-2546

cc: