

Personal Service Insurance Company
PO Box 3001
Plymouth Meeting, PA 19462
Ph: 610.832.4940 Fax: 610.832.2138
Toll Free: 800.954.2442

Date (##/##/####)

Physician Name
Street Address
City, State, Zip

Claimant:
Claim Number:
Medlogix ID #:
Date of Accident:
Insured:

Dear Provider:

This letter is to advise you that Consolidated Services Group, Inc. (CSG) is handling decision point review/pre-certification, medical service review and medical fee schedule calculations of this claim for Personal Service Insurance Company (PSI), your patient's no-fault insurance carrier. Pursuant to N.J.A.C. 11:3-4, you are required to notify us of those services you intend to perform on the patient, as hereinafter explained. PSI has contracted with Consolidated Services Group, Inc. (the "PIP Vendor") for these purposes.

In accordance with N.J.A.C. 11:3-4.7(c) 3, a copy of the informational materials for policy holders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through our website @ www.personalserviceinsurance.com and Consolidated Services Group, Inc. website @ www.medlogix.com.

Please note, no decision point or pre-certification requirements shall apply within 10 days of the insured event or to treatment administered in emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

Also included in the enclosed information is a "Conditional Assignment of Benefits" form for you and your patient to sign. Acceptance of assignment of benefits will be conditioned on Personal Service's receipt of a properly executed form, your acceptance of, and compliance with, the conditions stipulated therein. Please review the Conditional Assignment of Benefits carefully as it has been updated with additional conditions. These conditions apply to claims, such as this, with a date of loss and Personal Service policy renewal date on or after July 1, 2011. Providers who sign Personal Service's Conditional Assignment of Benefits for this claim agree to submit

disputes as defined in the Plan to an Internal Dispute Resolution process. Providers also agree to 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.

Providers who do not sign Personal Service's Conditional Assignment of Benefits are not eligible to submit PIP disputes to the Personal Injury Protection Dispute Resolution process.

A copy of the Conditional Assignment of Benefits is also available at Personal Service's web site, www.personalserviceinsurance.com. If completed, please forward the Conditional Assignment of Benefits to the Personal Service claim office indicated above.

The Plan includes forums for dispute resolution: Internal Dispute Resolution and Personal Injury Protection Dispute Resolution set forth in N.J.A.C. 11:3-5. These forums are also described in the enclosed Plan.

Providers who retain counsel to assist them in the Internal Dispute Resolution process do so strictly at their own expense. Personal Service will not reimburse providers for their counsel fees or any other costs regardless of the outcome of the process.

CARE PATHS/DECISION POINT REVIEW

As mentioned above, pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance (the "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the "Identified Injuries". N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests. The Care Paths provide that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, you must provide us information about further treatment you intend to provide. This is called **Decision Point Review**. In addition, the administration of any test listed in N.J.A.C. 11:3-4.5(b) 1-10 also requires Decision Point Review, regardless of the diagnosis. If you fail to submit requests for Decision Point Reviews or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. The **Care Paths** and accompanying rules are available on the Internet at the Department's website at www.nj.gov/dobi/aicrapg.htm or can be obtained by contacting CSG @ 1 (877) 258-CERT (2378).

MANDATORY PRE-CERTIFICATION

If your patient does not have an Identified Injury, you are required to obtain pre-certification of all the services listed below. If you fail to submit requests for the pre-certification of all the services listed below or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that

applies under the policy) of the eligible charge for medically necessary services. You are encouraged to maintain communication with CSG on a regular basis as pre-certification requirements may change. Pre-certification is mandatory as to any of the following medical services once 10 days have elapsed since the accident:

- (a) non-emergency inpatient and outpatient hospital care
- (b) non-emergency surgical procedures
- (c) extended care rehabilitation facilities
- (d) outpatient care for soft tissue/disc injuries of the insured person's neck, back and related structures not included within the diagnoses covered by the Care Paths
- (e) physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation except that provided for Identified Injuries in accordance with Decision Point Review
- (f) outpatient psychological/psychiatric testing and/or services
- (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 restoration
- (j) temporomandibular disorders; any oral facial syndrome
- (k) infusion therapy
- (l) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$75.00.

HOW TO SUBMIT DECISION POINT REVIEW/PRE-CERTIFICATION REQUESTS

In order for CSG to complete the review, you are required to submit all requests on the “Attending Physicians Treatment Plan” form in accordance with order number A04-143 A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, CSG’s web site www.medlogix.com or by contacting CSG @ (877) 258-CERT (2378).

Please return this completed form, along with a copy of your most recent/appropriate progress notes and the results of any tests relative to the requested services to CSG via fax at (856) 910-2501 or mail to the following address: CSG, Inc., 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002, ATTN.: Pre-Certification Department. Its phone number is (877) 258-CERT (2378).

The review will be completed within three (3) business days of receipt of the necessary information and notice of the decision will be communicated to your office by telephone and/or confirmed in writing. If you are not notified within 3 business days, you may continue your test or course of treatment until such time as the final determination is communicated to you. Similarly, if an independent medical examination should be required, you may continue your tests or course of treatment until the results of the examination become available.

Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

INDEPENDENT MEDICAL EXAMS

If the need arises for CSG to utilize an independent medical exam during the decision point review/pre-certification process, the guidelines in accordance to 11:3-4.7(e) 1-7 will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam.

If the injured person has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place the injured person on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

POSSIBLE OUTCOMES

The following are the possible outcomes of our review:

- (a) The requested service is certified.
- (b) If CSG receives information that, in their view, is insufficient to support the requested test or service, they will issue an administrative non-certification and will continue to non-cert the requested test or service until such time as they receive documentation sufficient to evaluate the request.
- (c) In the event CSG feels a change in the requested test or service is advisable (whether in frequency, duration, intensity or place of service or treatment), they will notify your office of the modified results
- (d) In the event CSG is unable to certify your request, your office will be notified of the results and a CSG Medical Director will be available through an internal reconsideration process to discuss the case with you. CSG may also request that the patient undergo an Independent Medical Examination. Any such exam will be scheduled in accordance with 11:3-4.7(e) 1-7 as stated In the Independent Medical Exams section above.

VOLUNTARY UTILIZATION PROGRAM

In accordance with N.J.A.C. 11:3-4.8(b) the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery
2. Computer Assisted Tomography
3. The electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3, except when performed by the treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$75.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility

When one of the above listed services, tests or equipment is requested through the decision point review/pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to the injured person or his or her designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred provider networks to obtain the medically necessary services, tests or equipment requested. In accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in an additional co-payment not to exceed 30 percent of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, visit CSG's website @ www.medlogix.com, contact CSG by phone @ (877) 258-CERT (2378), via fax @ (856) 910-2501, or in writing @ 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002.

INTERNAL DISPUTE RESOLUTION PROCESS

Under Personal Service Insurance Company's Conditional Assignment of Benefits, the provider shall be required to submit disputes to the Internal Dispute Resolution process before submitting the disputes to Personal Injury Protection Dispute Resolution under N.J.A.C. 11:3-5, et seq.

To submit an issue to the Internal Dispute Resolution process, the provider must complete an Internal Dispute Resolution request form and select a physician to review the dispute from a list maintained by CSG. If the provider does not select a reviewing physician, one will be selected on the provider's behalf. The request form and any supporting documentation must be submitted to PSI. The reviewing physician's Internal Dispute Resolution decision will be communicated to the provider no more than 30 days after receipt of the request form and all pertinent medical information required to review the dispute. The decision by the reviewing physician is non-binding to all parties.

The Internal Dispute Resolution process is an attempt to resolve disputes directly between PSI and the provider. Providers who retain counsel to assist them in the Internal Dispute Resolution process do so strictly at their own expense. PSI will not reimburse providers for their counsel

fees or any other costs regardless of the outcome of the process.

The Internal Dispute Resolution request form is available at PSI's website at www.personalserviceinsurance.com or at CSG's website at www.medlogix.com. The list of physician reviewers is available at CSG's website at www.medlogix.com.

PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

A PIP dispute, as defined by N.J.A.C. 11:3-5, may be submitted to Personal Injury Protection (PIP) Dispute Resolution in accordance with the Personal Service Insurance Company policy. PIP Dispute Resolution shall be conducted in accordance with the procedures set forth in N.J.A.C. 11:3-5, including any amendments. The final determination made by the dispute resolution professional shall be binding on the parties, but subject to vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A 2A:23A-13 for review of the award.

Under PSI's Conditional Assignment of Benefits, after exhausting the Internal Dispute Resolution process, a provider must submit any PIP dispute, as defined by N.J.A.C. 11:3-5, to PIP Dispute Resolution in accordance with this Plan.

ASSIGNMENT OF BENEFITS

As a condition of the assignment of benefits, the treating medical provider or provider of service benefits agrees to comply with all the procedures of the Plan. The provider also agrees to initiate all Pre-certification and Decision Point Review requests as required by the Plan. In the event the provider fails to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, the provider will hold the patient harmless for such co-payment penalty insofar as the provider will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. Additional conditions that also apply to the provider include:

- a) Submission of disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute Resolution process may be submitted to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
- b) Submission of medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.

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

Should you have any questions or require any further information not available through the websites, don't hesitate to contact us or CSG.

Sincerely,

Personal Service Insurance Company

Enclosures: Conditional Assignment of Benefits