FREQUENTLY ASKED DECISION POINT REVIEW/PRE-CERTIFICATION QUESTIONS

INTRODUCTION

At <<Policy_CompanyName>>, we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that carrier provide you first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This brochure explains how your medical claims will be handled, including the Decision Point Review/Precertification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Please read this brochure carefully. If you have any questions, please call your Claim Representative at <<Author_Phone>>.

PROMPT REPORTING

Question: What is prompt reporting and what are the penalties?

Answer: We require that the Insured/Eligible Person advise and inform us 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, we shall impose an additional co- payment as a penalty which shall be no greater than:

a) Twenty five (25) percent when received (30) or more days after the accident; or
b) Fifty (50) percent when received sixty (60) or more days after the accident.
At the request of Farmers or its vendor, a prompt report status may also occur every 60 days thereafter while the claim remains open to obtain updated information concerning the patient's medical condition.

Definitions:

"Medically necessary" or **"medical necessity"** means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths in the Appendix of NJAC 11:3-4, as applicable;

2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and

3. Does not include unnecessary testing or treatment.

"Standard Professional treatment protocols" means evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals.

"Utilization Management" means a system for administering some or all of an insurer's decision point review plan, including but not limited to, receiving and responding to decision point review and precertification requests, making determination of medical necessity, scheduling and performing independent medical examinations (IMEs) bill review and handling of provider appeals.

"PIP vendor" means a company used by an insurer for utilization management.

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Please note: Under the provisions of your policy and applicable New Jersey regulations, Decision Point Reviews and/or Pre-certification of specified medical treatment and testing is required in order for medically necessary expenses to be fully reimbursable under the terms of your policy. The following questions and answers only provide an overview of Decision Point Reviews and Pre-certification requirements. You should read your policy for the actual Pre-certification requirements as well as other policy terms and conditions.

Treatment in the first 10 calendar days after an accident and emergency care does not require Decision Point Review or Pre-certification. However, for benefits to be paid in full, the treatment must be medically necessary. This is true in all events.

Question: What is a Decision Point Review?

Answer: 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". These Care Paths provide your health care provider with general guidelines for treatment and diagnostic testing as to these injuries. In addition the Care Paths require that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, your health care provider must provide us information about any further treatment or test required. This is called **Decision Point Review.** During the Decision Point Review process, all services requested are evaluated by medical professionals to insure the level of care you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries.

However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you to receive maximum reimbursement under the policy. 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. 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 at 1 (877) 258-CERT (2378).

Question: What is Pre-certification?

Answer: Pre-certification is a medical review process for the specific services, test or equipment listed below in (a)-(n). During this process all services, test or equipment requested are evaluated by medical professionals to insure the level of services, tests or equipment you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Pre-certification requirements in order for you to receive maximum reimbursement under the policy.

(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 including but not limited to the following:
    1. acupuncture,
    2. nerve blocks,
    3. manipulation under anesthesia,
    4. epidural steroid injections,
    5. radio frequency/rhyzotomy,
    6. narcotics, when prescribed for more than three months,
    7. biofeedback,
    8. implantation of spinal stimulators or spinal pumps, and
    9. trigger point injections
    10. non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $75.00
(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.
(m) Computerized muscle testing; Current perceptual testing; Temperature gradient studies; Work hardening; Carpal Tunnel Syndrome; Vax D and DRX; Podiatry; Audiology; Bone Scans
(n) Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.

Should you require any of the following requests, please consult your claim representative to discuss the claims process for payment consideration.

1. modifications to vehicles,
2. furnishings,
3. improvements or modifications to real or personal property,
4. fixtures,
5. gym memberships.

Tests for Which the Law Prohibits Coverage under Any Circumstances

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.

Pursuant to **N.J.A.C.** 11:3-4.5(f) and 13:30-8.22(b), we shall 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):

1. Mandibular tracking;
2. Surface EMG;
3. Sonography;
4. Doppler ultrasound;
5. Needle EMG;
6. Electroencephalogram;
7. Thermograms/thermographs;
8. Videofluoroscopy; and
9. Reflexology.

Question: What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?

Answer: Provide us with the name(s) of your medical providers. We will then contact them to explain the entire process. In addition, you are required to give us notice, proof of claim and other reasonably obtainable information in the form of a signed Application for No-Fault Benefits within 30 calendar days after the accident. You should also give your medical provider a copy of the "*Dear Provider Letter*" included with this brochure.

Question: How does the Decision Point Review/Pre-certification Process Work?

Answer: In order for CSG to complete the review, your health care provider is required to submit all requests on the "Attending Providers Treatment Plan" form as adopted by the DOBI. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, CSG's web site http://www.csg-

inc.net/nj_auto_plans.htm or by contacting CSG at (877) 258-CERT (2378).

The health care provider should submit the completed form, along with a copy of their 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., 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, 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 both you and your health care provider by fax and/or confirmed in writing. A business day is any day except Saturday, Sunday or a legal holiday between the hours of 7:00 AM EST and 7:00 PM EST. In computing any business day time period, the day from which the designated period of time begins to run shall not be included per 11:3-4.2. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available.

Example: Response to a properly submitted provider request is due back no later than 3 business days from the date CSG receives the submission. CSG receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday, February 6, 2013. Day one of the 3-business day period is Thursday, February 7, 2013. Since the 3rd day would be Saturday, February 9, 2013, CSG's decision is due no later than close of business Monday, February 11, 2013.

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

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?

Answer: 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 providers 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 examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

Failure to attend the physical/mental examination request will be **excused** if the injured person notifies Farmers or CSG at least three (3) business days before the examination date of his or her inability to attend the exam. Another exam will then be scheduled to occur within the thirty-five (35) calendar days.

Failure to attend a physical/mental examination scheduled request will be **unexcused** if the injured person does not notify Farmers or CSG at least three (3) business days before the examination date of his or her inability to attend the exam.

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

PRE-SERVICE APPEALS

Question: Can my health care provider appeal the Decision Point Review or Pre-certification decision?

Answer: Yes. Per N.J.A.C. 11:3-4.7B, effective 4/17/17, a pre-service appeal of a decision point review and/or precertification denial or modification must be submitted no later than thirty (30) days after receipt of a written denial or modification of requested services.

In accordance with N.J.A.C. 11:3-4.7B(c), appeals must be submitted on the pre-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm). The properly completed pre-service appeal form and any supporting documentation must be submitted to CSG. In accordance with N.J.A.C.11:3-4.7B, a pre-service appeal decision will be provided to your health care provider within fourteen (14) calendar days from receipt of the properly completed pre-service appeal form and any supporting documents submitted by your health care provider or any documentation requested by us in order to complete our review. This process will afford your health care provider the opportunity to discuss the appeal with a "similar discipline" Medical Director or request an independent examination scheduled by CSG. Failure to submit a properly completed pre-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for pre-service appeals.

Disputes concerning medical necessity of a denial or modification of a treatment request, are to be made as pre-service appeals. The pre-service appeals process must be completed prior to the performance or issuance of the requested service.

Pre-service appeals must be submitted directly to CSG, via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

Pre-service appeals will only be considered valid if they are submitted to CSG at the address or fax number listed here. If your health care provider has accepted an assignment of benefits, or has a power of attorney, they are required to participate in this process. Failure to participate in this process shall void the assignment of benefits and/or power of attorney.

POST-SERVICE APPEALS

Question: How can I or my health care provider appeal other disputes not related to a Decision Point Review or Pre-certification decision such as non-payment or reduced payment of a bill?

Answer: Effective 4/17/17, if any payment or non-payment is unacceptable to you or your health care provider, <<Policy_CompanyName>> provides an Internal Appeal Process which is available for review of the decision to which they object. A post-service appeal must be submitted at least 45 days prior to initiating alternative dispute resolution pursuant to N.J.A.C. 11:3-5 or filing action in Superior Court.

In accordance with N.J.A.C. 11:3-4.7B(c), appeals not related to pre-certification must be submitted on the post-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm).

In accordance with N.J.A.C.11:3-4.7B , a post-service appeal decision will be provided to your health care provider within thirty (30) calendar days from receipt of the properly completed post-service appeal form and any supporting documents submitted by your health care provider or any documentation requested by us in order to complete our review. Failure to submit a properly completed post-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for post-service appeals.

The properly completed post-service appeal form and any supporting documentation, must be submitted to 21st Century Centennial Insurance via fax to (844) 570-8231, or via certified mail to: New Jersey Appeals Administrator, 21st Century Centennial Insurance, 400 Colonial Center Parkway, Suite 200, Lake Mary, FL 32746. Post service appeals will only be considered valid if they are submitted to the fax number or address listed here.

If your health care provider has accepted an assignment of benefits, or has a power of attorney, they are required to participate in this process. Failure to participate in this process shall void the assignment of benefits and/or power of attorney.

Question: Am I or my health care provider required to submit a pre-service appeal and a post-service appeal for the same service?

Answer: The appeal process described above provides only one-level appeal prior to submitting the dispute to alternative dispute resolution or litigation. You or your health care provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. You or your health care provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement of that treatment.

Question: Can I or my health care provider retain counsel for the Internal Appeal Process?

Answer: If you or your health care provider retain counsel for representation during the Internal Appeal Process, you or your health care provider do so strictly at your own expense. No reimbursement will be issued for counsel fees or any costs regardless of the outcome of the appeal.

VOLUNTARY UTILIZATION PROGRAM

Question: Does the plan provide voluntary networks for certain services, tests or equipment?

Answer: In accordance with the regulations, 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 for needle EMGs, H-reflex and nerve conduction velocity (NCV) tests performed together 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.
6. Prescription drugs

Question: How do I gain access to one of these networks?

Answer: 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 you, and the requesting health care provider. The notice will include how to acquire a list of available voluntary provider networks, with phone numbers and addresses, 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 voluntary provider networks through the process outlined in the paragraph above, visit CSG's website at http://www.csg-inc.net/nj_auto_plans.htm, contact CSG by phone at (877) 258-CERT (2378), via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

PENALTY CO-PAYMENTS

Question: Why would payment of my bills for health care services, tests and durable medical equipment be subject to additional co-pay, and how much is it?

Answer: If your health care provider does not comply with the decision point review/pre-certification previsions of the plan, including failure to submit a request for decision point review/precertification or failure to provide clinically supported findings that support the request, payment of those services rendered will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a voluntary network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

In addition, you are required to give notice, proof of claim and other reasonably obtainable information in the form of a signed Application for No-Fault Benefits form within 30 days after the accident. If you fail to provide us with the required information, we may impose an additional co-payment (in addition to any deductible or co-payment that applies under the policy). The additional co-payment shall be an amount no greater than:

- Twenty-five percent when received 30 or more days after the accident; or
- Fifty percent when received 60 or more days after the accident.

ASSIGNMENT OF BENEFITS

Question: Can I assign my benefits?

Answer: Yes, but only to a provider of service benefits. If a valid assignment is made by you and accepted by the provider of the assigned services benefits, the provider:

(a) agrees to follow the requirements of our decision point review plan for making decision point review and precertification requests;
(b) agrees to hold you harmless for penalty co-payments imposed by us based on the provider's failure to follow the requirements of our Decision Point Review Plan;
(c) agrees to follow the Internal Appeal Process for disputes arising out of a request for Decision Point Review or Precertification;
(d) agrees to follow the Internal Appeal Process for Other Disputes for any issues other than a decision related to a treatment request; and
(e) agrees to submit disputes to PIP Dispute Resolution pursuant to N.J.A.C. 11:3-5. However, prior to submitting to PIP Dispute Resolution, the provider must comply with the requirements of (c) and (d) above.

Failure on the part of your provider to comply with (a), (b), (c), (d) and (e) above, will render any assignment of benefits null and void.

NO COVERAGE IS PROVIDED BY THIS BROCHURE OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS BROCHURE DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

<<Policy_CompanyClaims>>
<<Policy_CompanyClaimsAddress>>
<<Author_FirstName>> <<Author_LastName>>
<<Author_Phone>>
Fax: (877) 217-1389

For: <<Policy_CompanyName>>