

Farmers Insurance Exchange
Mid-Century Insurance Company
Personal Injury Protection Benefits
New Jersey Decision Point Review Plan

Pursuant to N.J.A.C. 11:3-4.7, the following Decision Point Review Plan (DPRP) is submitted to the New Jersey Department of Banking and Insurance for approval. This DPRP includes a description of the requirements of the DPRP and samples of the claimant and provider communications described in N.J.A.C.11:3-4.7(d).

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 N.J.A.C. 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**” mean 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 pre-certification 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. Farmers Insurance has selected Consolidated Service Group (CSG) to be its partner for providing Decision Point review and Pre-certification review under this plan.

PROMPT REPORTING

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 thirty (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 sixty (60) days thereafter while the claim remains open to obtain updated information concerning the patient’s medical condition.

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Please note: Under the provisions of this DPRP, and applicable New Jersey regulations, Decision Point Review and/or Pre-certification of specified medical treatment and testing is required in order for medically necessary expenses to be fully reimbursable.

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

DECISION POINT REVIEW

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 the health care provider with general guidelines for the treatment and diagnostic testing of these injuries. In addition, the Care Paths require treatment evaluation at certain intervals called Decision Points. At Decision Points, the 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, medical professionals evaluate all requested services to ensure the level of care the injured party is receiving is medically necessary for the injuries. The health care provider is required to follow the Decision Point Review requirements in order for the injured party to receive maximum reimbursement under the policy and DPRP. 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, on our website at <https://www.farmers.com/claims/medical-claims> or can be obtained by contacting CSG at 1 (877) 258-CERT (2378).

MANDATORY PRE-CERTIFICATION

Pre-certification is a medical review process which applies to the specific services, tests or equipment listed below in (1)-(15). During this process all services, tests or equipment requested are evaluated by medical professionals to ensure the level of services, tests or equipment requested is medically necessary.

1. Non-emergency inpatient and outpatient hospital care;
2. Non-emergency surgical procedures;
3. Extended care rehabilitation facilities;
4. Outpatient care, including follow-up evaluations, 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;
5. Physical, occupational, speech, balance disorders, cognitive or other restorative therapy or other body part manipulation except that provided for Identified Injuries in accordance with Decision Point Review;
6. Outpatient psychological/psychiatric testing and/or services;
7. All pain management services except as provided for identified injuries in accordance with decision point review including but not limited to the following:
 - a. Acupuncture;
 - b. Nerve blocks;
 - c. Manipulation under anesthesia;
 - d. Epidural steroid injections;
 - e. Radio frequency ablation/destruction by neurolytic agent/rhizotomy;
 - f. Narcotics, when prescribed for more than three months;

- g. Pain Cream and/or Compounded pain medicine;
 - h. Biofeedback;
 - i. Implantation of spinal stimulators or spinal pumps;
 - j. Trigger point injections; and
 - k. 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.
8. Home health care;
 9. Non-emergency dental restoration;
 10. Temporomandibular disorders; any oral facial syndrome;
 11. Infusion therapy;
 12. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$75.00;
 13. Computerized muscle testing; Current perceptual testing; Temperature gradient studies; Work hardening; Carpal Tunnel Syndrome; Vax D and DRX; Podiatry; Audiology; Bone Scans;
 14. Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code; and
 15. Non-emergency drug screen testing.

Should the injured party require any of the following requests, please consult the 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; and
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.

ADDITIONAL REQUIREMENTS

Written documentation to be supplied to Farmers must be legible and clinically supported and 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 indication 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.

HOW TO SUBMIT DECISION POINT REVIEW/PRE-CERTIFICATION REQUESTS

In order for CSG to complete the review, the 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).

Health care providers 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 decision point review/pre-certification review will be completed within three (3) business days of receipt of the necessary information. Notice of the decision will be communicated to both the claimant and 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 N.J.A.C. 11:3-4.2. If the health care provider is not notified within three (3) business days, they may continue with the requested 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 the 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 three (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 three (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

If the need arises for CSG to utilize an independent medical exam during the decision point review/pre-certification process to determine the medical necessity of the requested treatment or testing, the guidelines in accordance to N.J.A.C. 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 (7) 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 (3) business days after attendance of the exam. If the examining provider prepares a written report concerning the examination, the claimant, or 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.

Two or more unexcused failures to attend a scheduled exam will result in termination of benefits for the diagnosis (and related diagnoses) contained in the attending provider treatment plan form. Notification will be immediately sent to the claimant and all health care providers treating for the diagnosis (and related diagnoses) contained in the attending providers treatment plan form. The notification will place the claimant on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnoses) contained in the attending providers 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:

1. The requested service is certified.
2. 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.
3. 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.
4. 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 appeal 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 N.J.A.C. 11:3-4.7(e) 1-7 as stated in the Independent Medical Exams section above.

REPORTING REQUIREMENTS

For injuries *other than* the identified injuries outlined in the CARE PATH AND DECISION POINT and MANDATORY PRE-CERTIFICATION SECTION above.

1. We must be provided with written support establishing the need for further treatment before reimbursement may be considered. This documentation is required if medical treatment is necessary beyond the first thirty (30) calendar days following the accident. We encourage the submission of comprehensive treatment plans for all injuries to avoid periodic reviews when continued treatment is considered medically necessary for an extended period of time. If a comprehensive treatment plan has not been submitted and approved, notification is required every sixty (60) calendar days following the date of the accident for as long as continued treatment is necessary if coverage is sought. As long as the treatment, diagnostic testing and/or durable medical equipment rendered/supplied is consistent with the approved treatment plan, additional notification every sixty (60) calendar days following the accident is not required. Once a treatment plan has been approved, you or our insured must notify us in writing of the medical necessity of any treatment, diagnostic testing or durable medical equipment that varies from the approved treatment plan before reimbursement will be considered.
2. Failure to provide the notification required in paragraph one of this section, may result in a co-payment penalty on eligible medical charges of 25 percent if notice is received thirty (30) or more calendar days after the accident or 50 percent when received sixty (60) or more calendar days after the accident even if services are determined to be medically necessary.

INTERNAL APPEAL PROCESS

<<PolicyCompanyName>> provides an Internal Appeal Process which is available for review of any decision to which the injured party or health care provider object.

The Internal Appeal Process includes pre-service appeals and post-service appeals.

The Internal Appeal Process shall be completed before filing arbitration. If the health care provider has accepted an assignment of benefits or has a power of attorney from the insured, the Internal Appeal Process must be followed prior to the initiation of any arbitration or litigation. Failure to participate in this process shall void the assignment of benefits and/or power of attorney.

The Internal Appeal Process is streamlined to address Treatment Requests Disputes as well as Other Disputes (those other than treatment requests). Appeals relating to Treatment Requests are to be submitted to CSG. Appeals relating to Other Disputes including bill payment are to be submitted to <<Policy_CompanyName>>.

The appeal process described below provides only one-level appeal prior to submitting the dispute to alternative dispute resolution or litigation. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The pre-approval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement of that treatment.

Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution or litigation.

If the injured party or health care provider retains counsel to represent them during the Internal Appeal Process, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any costs regardless of the outcome of the appeal.

We are not required to pay for tests, treatment, services, or equipment that are not medically necessary and/or medical expenses that are not reasonable and necessary.

PRE-SERVICE APPEAL PROCESS

Per N.J.A.C. 11:3-4.7B, effective April 17, 2017, a pre-service appeal of a decision point review and/or pre-certification 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 the health care provider within fourteen (14) days from receipt of the properly completed pre-service appeal form and any supporting documents submitted by the health care provider or any documentation requested by us in order to complete our review. This process will afford the 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.

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 the 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 APPEAL PROCESS

Effective April 17, 2017, if any payment or non-payment is unacceptable to the claimant or health care provider, a post-service appeal must be submitted at least forty-five (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 the health care provider within thirty (30) days from receipt of the properly completed post-service appeal form and any supporting documents submitted by the 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 <<Policy_CompanyName>> via fax to (856) 642-9237, or via certified mail or another courier that provides proof of delivery to: New Jersey Appeals Administrator, <<Policy_CompanyName>>, 1000 Midlantic Drive, Suite 200, Mt. Laurel, NJ 08054. Post service appeals will only be considered valid if they are submitted to the fax number or address listed here.

If the 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.

VOLUNTARY UTILIZATION PROGRAM

In accordance with the regulations, the plan includes a voluntary utilization program for the following non-emergency goods or services:

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; and
6. Prescription drugs.

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 health care provider. The notice will include how to acquire a list of available voluntary provider networks, to obtain the medically necessary services, tests or equipment requested.

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.

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.

PENALTY CO-PAYMENTS

Treatment which is not medically necessary is not reimbursable under the terms of the policy.

If the health care provider does not comply with the decision point review/pre-certification provisions of the plan, 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, tests and equipment. This includes failure to submit a request for decision point review/pre-certification or failure to provide clinically supported findings that support the request.

Failure to utilize a voluntary network provider/facility to obtain services, tests, medicine or equipment listed in the voluntary utilization review program section, 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 and /or DPRP.

In addition, the claimant is 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 thirty (30) days after the accident. Failure to provide us with the required information, may result in an additional co-payment (in addition to any deductible or co-payment that applies under the policy). The additional copayment shall be an amount no greater than:

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

ASSIGNMENT OF BENEFITS

If a valid assignment of benefits is made by the claimant and accepted by the health care provider, the health care provider:

1. Agrees to follow the requirements of our decision point review plan for making decision point review and pre-certification requests;
2. Shall hold the injured party harmless for penalty co-payments imposed by us based on the provider's failure to follow the requirements of our Decision Point Review Plan;
3. Agrees to follow the Internal Appeal Process for disputes arising out of a request for Decision Point Review or Pre-certification;
4. Agrees to follow the Internal Appeal Process for any issues other than a decision related to a treatment request; and
5. 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 (3) and (4) above.

Failure on the part of the provider to comply with (1), (2), (3), (4) and (5) above, will render any assignment of benefits null and void.

In accordance with N.J.A.C. 11:3-4.7(d) this Decision Point Review Plan and informational materials for policyholders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through the Consolidated Services Group, Inc. website @ www.csg-inc.net/nj_auto_plans.htm

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