Narrative Description of the Generic Decision Point Review/Pre-certification Plan

CSG Hours of Operation – 8:00 AM to 5:00 PM EST Monday through Friday (excluding legal holidays)

At the time of policy issuance and renewal a Question and Answer brochure (see example under correspondence section) will be distributed to the policyholder. This document will outline all key elements/requirements/responsibilities of the plan as required in N.J.A.C. 11:3-4.7(d)1-9. This information will also be made available on the World Wide Web at Liberty Mutual Insurance Group, Inc.'s site **www.libertymutual.com** and CSG's site www.csg-inc.net/njauto.

When an injured person notifies the insurer of a claim, the insurer will send out a PIP packet including but not limited to the Question and Answer Introduction brochure (see example under correspondence section) to bring along with any upcoming visits for medical services, tests or equipment.

As required under N.JA.C. 11:3-4.4(e) to 11:3-4.4(f), the insured, injured person or treating provider may notify the insurer and/or CSG of the health care providers supplying treatment, diagnostic tests, prescription drugs or durable medical equipment. All identified health care providers will receive the Dear Provider letter outlining the duties and responsibilities of all involved parties and the consequences for failure to comply.

Upon receipt of the Attending Physicians Treatment Plan form and related supporting documents, CSG will complete a medical necessity review within three business days.

The definition of days is as follows: "Days" means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours 5:00 PM EST Monday through Friday (excluding legal holidays).

2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time designated as calendar or business day is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.
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-buisness 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.

CSG will communicate the findings (administrative non-certification, approval, modification or denial) to the requesting health care provider and injured person or his or her designee on a Care Plan Evaluation letter.

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.

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 (unless the injured person agrees to extend the time period) through a detailed scheduling letter sent to the injured person or his or her designee, 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 on a Care Plan Evaluation letter. If the examining provider prepares a written report concerning the examination, the injured person, or his or her designee shall be entitled to a copy upon written request.

If the Injured Party/Examinee cannot attend a scheduled examination, CSG must be contacted at least three (3) business days prior to the scheduled examination by phone @ (877) 258-CERT (2378, fax @ (856) 910-2501, or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Pre-Certification Department. The examinee is required to supply proper photo identification to the examining provider and, if the examinee is non-English speaking, then an English speaking interpreter must accompany the examinee (Interpreter fees and costs are not compensable or reimbursable.). The examinee/designee must provide all pertinent medical records and diagnostic studies/tests available before, or at the time, of the examination. In addition, the examinee must cooperate fully with the examining physician and may be asked to bring specific prescribed durable medical equipment items to the examination. Failure to comply with any of the provisions as stated in this paragraph will be considered an unexcused absence to attend the scheduled exam.

If the injured person has more than one unexcused failures to attend the scheduled exam, notification will be immediately sent (on a Care Plan Evaluation letter) 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 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.

If a treating health care provider fails to submit a request for decision point review/pre-certification or fails to provide clinically supported findings that support the request as outlined in the plan,

payment of medically necessary services will result in co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge.

If CSG fails to respond to a request within three business days, the treating health care provider may continue with the course of care until CSG communicates its findings.

A provider can participate in CSG's internal appeals process. All appeals must be initiated using the forms established by the New Jersey Department of Banking and Insurance. A copy of these forms can be found on the New Jersey Department of Banking and Insurance website**,** CSG's website (www.csg-inc.net/njauto), or by contacting CSG at (877) 258-CERT (2378).

There are two types of appeals, each with a separate and specific workflow, which will be considered:

Pre-Service Appeals: This is an appeal of the denial or modification of a decision point review or precertification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, durable medical equipment, and/or other service on the basis of medical necessity.

For the NEW JERSEY PIP PRE-SERVICE APPEAL FORM, the minimum required information (identified by form section number) is as follows: The key dates (sections 1-2), CLAIM INFORMATION (sections 3-5), PATIENT INFORMATION (sections 6-7 and 9-13), PROVIDER/FACILITY INFORMATION (sections 14-25), DOCUMENTS INCLUDED (section 29 indicated with asterisk), PRE-SERVICE APPEAL ISSUES (sections 30-31, and 32, 33, or 34), and the signature information (sections 35-36).

The New Jersey PIP Pre-Service Appeal Form and any supporting documentation shall be submitted by the provider to CSG via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A pre-service appeal must be submitted no later than 30 days after receipt of a written denial or modification of requested services. Decisions on pre-service appeals shall be issued by CSG or the insurer to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it is determined that new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc.) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-Service Appeals: This is an appeal subsequent to the performance or issuance of the services rendered and can include, but is not limited to, bill review issues, payment or non-payment.

For the NEW JERSEY PIP POST-SERVICE APPEAL FORM the minimum required information (identified by form section number) is as follows: The key dates (sections 1-2), CLAIM INFORMATION (sections 3-5), PATIENT INFORMATION (sections 6-7 and 9-13), PROVIDER/FACILITY INFORMATION (sections 14-25), DOCUMENTS INCLUDED

(section 29 indicated with asterisk), POST-SERVICE APPEAL ISSUES (sections 30-31, 33 and/or 38 and 34-36 if completing section 38), and the signature information (sections 39-40).

The New Jersey PIP Post-Service Appeal Form and supporting documentation must be submitted to Liberty Mutual Insurance in writing at P.O. Box 515097, Los Angeles, CA 90051-5097.

A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court. Decisions on post-service appeals shall be issued by the insurer or CSG to the party who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it is determined that new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis, etc.) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

A provider cannot submit a Pre-Service Appeal and then a Post-Service Appeal on the same issue. The preapproval of treatment and reimbursement for that treatment are separate issues.

This Internal Appeal Process provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution or litigation.

Failure to follow the Pre-Service and Post-Service appeal requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission and administrative denial does not constitute acceptance of the appeal within the required timeframes for Pre-Service and Post-Service appeals.

Any provider who has accepted an assignment of benefits is required to follow the Internal Appeal Process as described and agrees to exhaust such appeals process prior to submitting any dispute through alternate dispute resolution or litigation. Failure to utilize the Internal Appeal Process as outlined will invalidate any assignment of benefits.

If a claimant, provider, or assignee 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 other costs, regardless of the outcome of the appeal.

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 for needle EMGs, H-reflex and nerve conduction velocity (NVC) tests performed together by the treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $100.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility
6. Prescription Drugs

When one of the above listed services, tests, prescription drugs 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, prescription drugs or equipment requested. In the case of Prescription Drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of these participating pharmacies will be made available at time of card issuance. 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% of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, the injured person or his or her designee, and the requesting provider can visit CSG's website at www.csg-inc.net/njauto, 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.