

DECISION POINT REVIEW PLAN

NJ Department of Banking and Insurance has developed typical courses of treatment called (Care Paths) for certain types of injuries, called Identified Injuries. When treatment reaches a decision point, as indicated on the Care Paths, a decision must be made regarding further treatment or tests, called Decision Point Review. In addition, the administration of any of the tests listed in N.J.A.C. 11:3-4.5(b) is subject to Decision Point Review.

The following Decision Point Review Plan requirements are applicable only after the tenth day following the accident and do not apply to treatment administered in emergency care:

- (a) We must be provided written notice, with the appropriate clinically supported findings, that the administration of certain tests or proposed treatments is medically necessary.
- (b) Upon receiving notification with the appropriate clinically supported findings, we will review the notice and supporting materials within three business days. Clinically supported findings include diagnoses (ICD-9 codes) and clinical symptoms, diagnostic tests performed and their results, recommended tests and pre-existing conditions.
- (c) Following our review of the information required in paragraph (b) above, we may:
 - (i) Approve the proposed treatment or test if supporting documentation is sufficient and the request is deemed reasonable; or
 - (ii) Request further information if the information submitted is not sufficient to render a determination. After review of the further information we may authorize the proposed treatment or tests; or
 - (iii) Submit the request for further treatment or testing to BME Gateway for Decision Point Review. BME's review may include a physical examination of the injured person in accordance with (e) below where the notice and supporting materials and other medical records, if requested, are not sufficient to authorize or deny reimbursement of further treatment or tests.
- (d) You will be notified of our, or BME's, determination within three business days of receipt of the necessary information. If we, or BME, do not respond to a written Decision Point Review request within three business days of receipt of the request, the provider may proceed with the test or treatment until the provider receives our determination. Note: Any decision to deny a Decision Point Review request on the basis of medical necessity shall be the determination of a physician or dentist.
- (e) Physical Examination
 - (i) BME will notify the injured person if a physical examination is required. Treatment may proceed while the examination is being scheduled and until the results are available.
 - (ii) The medical examination will be:
 - 1) scheduled within seven calendar days of receipt of the notice described above unless the injured person agrees to extend the time period;
 - 2) conducted by a health care provider similar to the treating health care provider; and

- 3) conducted at a location reasonably convenient to the injured person.
- (iii) Upon our request, the treating health care provider or the injured person will provide medical records and other pertinent information to the health care provider conducting the medical examination. The requested records will be provided no later than the time of the examination.
 - (iv) BME will notify the injured person whether reimbursement for further treatment or test is authorized as promptly as possible, but no later than three days after the examination.
 - (v) If the examining provider prepares a written report regarding the Examination, a copy of the report is available upon 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 Provider Treatment Plan form. The notification will place all parties on notice that all future treatment, testing, durable medical equipment or prescription drugs required for the diagnosis and related diagnosis contained in the Attending Provider Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

Failure to request decision point review where required or failure to provide clinically supported finding that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment not to exceed 50 percent of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to us was required and the time that proper notification is made and we have an opportunity to respond in accordance with our approved decision point review plan.

In addition, we require that the insured advise and inform us about the injury and the claim, including the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of the treatment. We may impose an additional co-payment as a penalty for failure to supply the required information. Such penalties shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to us is required and until notification is received. The additional co-payment shall be an amount no greater than:

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

For the purpose of the co-payments permitted, the percentage reduction shall be applied to the amount that the insurer would otherwise have paid to the insured or the provider after the application of the provisions of N.J.A.C. 11:3-29. Such amount may have already been reduced by the application of the co-payments and/or deductibles.

We will not impose the additional co-payments if we received the required notice but failed to act in accordance with our *Decision Point Review Plan* to authorize or deny reimbursement of further treatment or tests.

RECONSIDERATION PROCESS (BME Reconsideration/Appeal Process)

If BME denies the request for certification of services, the clinical rationale for this determination is available upon written request. If the provider or the insured would like to have the decision reconsidered, they can participate in BME's internal review process by notifying BME in writing of their intention to participate in the reconsideration process to 600 Unicorn Park Drive, Woburn, MA. Requests for reconsideration must be made within 30 days of receipt of denial or modification and must include the reason for the request as well as supporting documentation. This process will afford the treating provider the opportunity to discuss the reconsideration with a "similar discipline" Medical Director.

If the provider has accepted an assignment of benefits, they are required to participate in this process prior to initiating arbitration or litigation. Submission of information identical to the initial material submitted in support of the request will not be accepted as a request for reconsideration. Provided that additional necessary medical information has been submitted, a response to the reconsideration request will be made within fourteen days of receipt of the request.

For dispute of issues other than requests for decision point review, any treating provider who has accepted an assignment of benefits must submit a written request for Reconsideration/Appeals specifying the issues in dispute accompanied by supporting documentation at least 21 days prior to initiating arbitration or litigation.

ASSIGNMENT OF BENEFITS

Assignment of the insured person's 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 assignment or 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 any disputes not resolved through the reconsideration process to Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5. Any assignment given to a provider who has failed to participate in the reconsideration/appeals process prior to submitting the dispute to Alternate Dispute Resolution shall be deemed void. The assignment is limited by statute and regulation to a licensed health care provider who complies with the restrictive language contained within the National Continental/Progressive Insurance Company's policy.

National Continental Insurance Company
No-Fault Unit
P.O. Box 7637
Princeton, NJ 08543-7637
609-750-2100/Toll Free Ph: 800-444-0013
Fax 609-452-8812/Toll Free Fax: 888-278-1586

Our Claim No. _____
Date of Loss: _____

We have received a report that you are presenting a No-Fault claim. New Jersey Regulations governing Automobile No-Fault Coverage have developed typical courses of treatment called Care Paths for certain injuries. These injuries include:

- Cervical Spine Soft Tissue Injury
- Cervical Spine Herniated Disc/Radiculopathy
- Thoracic Spine Soft Tissue Injury
- Thoracic Spine Herniated Disc/Radiculopathy
- Lumbar-Sacral Spine Soft Tissue Injury
- Lumbar-Sacral Herniated Disc/Radiculopathy

Enclosed you will find copies of these Care Paths.

Contained in these Care Paths you will notice *Decision Points* as indicated by a hexagon box. If and when the course of your treatment reaches one of these *Decision Points*, any further treatment will be subject to our *Decision Point Review Plan*. In addition, the administration of any tests listed in N.J.A.C. 11:3-4.5(b) 1-10 is subject to Decision Point Review. These tests are:

- Needle EMG
- Visual evoked potential (VEP)
- Brain evoked potential (BEP)
- Electroencephalogram (EEG)
- Magnetic resonance imaging (MRI)
- Sonograms/ultrasound
- Computer assisted tomographic studies (CT, CAT scan)
- Any additional diagnostic test that is subject to the requirements of the *Decision Point Review Plan* by New Jersey law or regulation.
- Somasensory evoked potential (SSEP)
- Brain audio evoked potential (BAEP)
- Nerve conduction velocity (NCV) & H-Reflex Study
- Videofluoroscopy
- Dynatron/cyber station/cybex
- Brain Mapping
- Thermograms/Thermography

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 of injuries sustained in an auto accident.

Please review our *Decision Point Review Plan* carefully. If you fail to comply with its requirements, you may be subject to reduced benefits or denial of benefits. Treatment in the first ten (10) days after the accident and emergency treatment do not require *Decision Point Review*.

Also enclosed, you will find a form entitled Attending Provider Treatment Plan form. You must provide this form to your primary treating physician for his/her use in the event of request for additional treatment and/or diagnostic testing to be covered when *Decision Point* is reached. Additional copies of this form are available by calling NCIC @ 1-800-444-0013 or on the New Jersey Department of Banking and Insurance website at <http://www.nj.gov/dobi/aicrapg.htm>

In addition to what is covered in the enclosed *Decision Point Review Plan* and Care Paths, please be advised, that in accordance with New Jersey Regulations, (11:3-4.5) the following Diagnostic tests will not be covered under your No-Fault Medical Benefits:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation

For the treatment of TMJ/D, the following diagnostic tests will not be covered under your No-Fault Medical Benefits:

- Mandibular tracking
- Sonography
- Needle EMG
- Thermograms / Thermographs
- Reflexology
- Surface EMG
- Doppler Ultrasound
- Electroencephalogram (EEG)
- Video fluoroscopy

Please share all information provided in the package with your primary treating physician. Should you have any questions regarding this information, please do not hesitate to contact your No-Fault Representative.

No-Fault Representative Name

Ph. 609-750-2130 or 1-800-444-0013