NEW JERSEY PROPERTY-LIABILITY INSURANCE GUARANTY ASSOCIATION DECISION POINT REVIEW PLAN INCLUSIVE OF PRECERTIFICATION REQUIREMENTS

This notice informs claimant of his/her rights and obligations under the Decision Point Review/Precertification Plan ("DPR Plan") utilized by the New Jersey Property-Liability Insurance Guaranty Association ("NJPLIGA"), in its capacity as the administrator of the claims of insolvent insurance companies and the Unsatisfied Claim and Judgment Fund ("UCJF") under the UCJF Law, N.J.S.A. 39:6-60 et seq.

The NJPLIGA DPR Plan and all applicable forms are available on the NJPLIGA website, www.njguaranty.org. Copies may also be obtained by contacting NJPLIGA at (908)382-7100.

DECISION POINT REVIEW

Pursuant to N.J.A.C. 11:3-4.1 et seq., the New Jersey Department of Banking and Insurance ("DOBI") has published standard courses of treatment, identified as **Care Paths**, for soft tissue injuries of neck and back, collectively referred to as **Identified Injuries**. N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests. All services must be medically necessary, clinically supported by information provided by claimant's treating health care provider and related to the injuries sustained in the accident.

The Care Paths provide for the evaluation of treatment at certain intervals called **Decision Points**. At Decision Points, claimant or claimant's treating health care provider must provide NJPLIGA information about further treatment the health care provider intends to perform. This is called **Decision Point Review**. Precertification is the pre-approval of medical procedures, treatments, diagnostic tests or other services, non-medical expenses and durable medical equipment ("DME") that are not subject to Decision Point Review. NJPLIGA will not pay for diagnostic testing that has no clinical value or is ineligible under the rules, regulations or laws of New Jersey or as determined by the DOBI as not being reimbursable. Information regarding Decision Point Review and the Care Paths is available on the DOBI's website at www.nj.gov/dobi/aicrapg.htm.

Pursuant to N.J.A.C. 11:3-4.7, treatment obtained in an emergency situation and/or within ten (10) days of the insured event, is not subject to Decision Point Review/Precertification requirements. This provision shall not be construed to require reimbursement of tests and/or treatment that are not medically necessary, N.J.A.C. 11:3-4.7(b). If claimant's treating health care provider fails to request Decision Point Review/Precertification when required or fails to provide clinical findings that support the treatment, testing or DME, a co-payment of fifty percent (50%) will apply even if the services are determined to be medically necessary.

NJPLIGA has designated a Medical Director to ensure Decision Point Review/Precertification requests are based upon medical necessity in accordance with N.J.A.C. 11:3-4.1 et seq. NJPLIGA will provide Decision Point Review, Precertification and other medical management services as permitted under New Jersey law, rules and regulations.

NJPLIGA will be available from 8:00 a.m. to 4:30 p.m. Monday through Friday to respond to provider Precertification requests and inquiries by phone (908)382-7100 or fax (908)382-7157. Voicemail will be activated for messages received on weekends, holidays and before or after hours and will be handled on the next business day.

DIAGNOSTIC TESTING

The following diagnostic tests are subject to Decision Point Review:

- Brain Mapping
- Brain Audio Evoked Potentials (BAEP)
- Brain Evoked Potentials (BEP)
- Computer Assisted Tomograms (CT, CAT scan)
- CAT/Mylogram
- Discogram
- Dynatron/Cybex Station/Cybex Studies
- Video Fluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography (Needle EMG)
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Magnetic Resonance Imaging (MRI)
- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Thermogram/Thermography
- Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation

Pursuant to N.J.A.C. 11:3-4.5, the following tests are prohibited under any circumstances:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)

- Mandibular tracking and stimulation
- 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), NJPLIGA will 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"):

- Mandibular tracking
- Surface EMG
- Sonography
- Doppler ultrasound
- Needle EMG
- Electroencephalogram
- Thermograms/thermographs
- Videofluoroscopy
- Reflexology

NOTIFICATION REQUIREMENTS

Upon notification of a covered injury, NJPLIGA will promptly provide the claimant with the following information: a letter summarizing the DPR Plan, Decision Point Review/Precertification procedures, the necessary no-fault forms, an introductory letter to the treating health care provider advising of the DPR Plan requirements and an authorization for release of medical information. Information will be provided on how to contact NJPLIGA to submit Decision Point Review/Precertification requests including telephone number, facsimile number and e-mail address. The circumstances under which a co-payment penalty may apply will be explained. Periodic communication with the claimant and the provider will occur as appropriate.

Decision Point Review will be conducted in accordance with the Care Path Treatment Protocols set forth in N.J.A.C. 11:3-4.1 et seq. and the standards for diagnostic tests set forth in N.J.A.C. 11:3-4.5. Decision Point means those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths where a decision must be made about the continuation or choice of further treatment. At each Decision Point, the treating health care provider is required to consult with NJPLIGA for Decision Point Review.

DECISION POINT REVIEW APPLIES TO THE FOLLOWING:

1. All treatment of accidental injury to the spine and back for ICD Codes specified in the Care Paths in N.J.A.C. 11:3-4.1 et seq.

2. All diagnostic tests identified in N.J.A.C. 11:3-4.5(b) for both identified and all other injuries.

For diagnostic tests, treatments, surgeries, services, DME and non-medical products, devices, services and activities identified below, the claimant's treating health care provider is required to obtain Precertification from NJPLIGA. Alternatively, the claimant or the treating health care provider may voluntarily agree to submit all proposed treatment to Precertification. Precertification requests must be submitted on the Attending Provider Treatment Plan ("APTP") Form approved by the DOBI. Copies of this form may be requested from NJPLIGA by calling (908)382–7100 or can be obtained at www.njguaranty.org or www.nj.gov/dobi/aicrapg.htm.

All requests for surgical procedures (CPT codes 10000-69999) require supplemental information including the name of the facility where services will be performed, the proposed surgery date, the need for and names of co-surgeons, assistant surgeons, physician assistants, and/or registered nurse first assistants as supported by the Centers for Medicare and Medicaid Services ("CMS") guidelines, anticipated post-operative services and care not included in the global fee period, including but not limited to, therapy, diagnostic testing and/or DME. This information should be submitted on the Surgery Precertification Request for NJ PIP Claims Form which is available at www.njguaranty.org or by contacting NJPLIGA. Requests for surgeries that do not include the necessary information will be administratively denied as deficient until the required information is provided.

All written documentation provided to NJPLIGA in support of a Precertification request must be clinically supported and establish that prior to selecting, performing or ordering the administration of a treatment, diagnostic test or DME, the treating health care provider has:

1. Personally examined the claimant to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or DME;
2. Physically examined the claimant including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications 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 DME; and
4. Recorded and documented those observations, positive and negative findings and conclusions on the claimant's medical records.

PRECERTIFICATION APPLIES TO THE FOLLOWING:

1. Non-emergency inpatient and outpatient hospital care (including the necessity and duration of the hospital stay).

2. Non-emergency surgical procedures.

3. Non-emergency surgery (performed in a hospital, freestanding surgical center or office) including implants and post-operative care and/or supplies not included in the global fee period. Pursuant to N.J.A.C. 11:3-29.4 et seq., global fee periods and the necessity for co-surgeon and assistant surgeons will be determined based upon the CMS Physician Fee Schedule and Medicare Claims Manual which can be found at www.cms.gov.

4. Non-emergency inpatient and outpatient psychological/psychiatric services and/or testing including biofeedback.

5. Infusion therapy.

6. Extended care and rehabilitation facilities.

7. All outpatient care, including follow-up evaluations, for soft tissue/disc injuries of the claimant's neck, back and related structures not included within the diagnoses covered by the Care Paths.

8. Temporomandibular disorders; any oral facial syndrome.

9. Carpal tunnel syndrome.

10. Home healthcare.

11. DME with an aggregate cost or monthly rental in excess of $50 and/or monthly rental greater than thirty (30) days including DME and associated supplies, prosthetics and orthotics.

12. Non-medical products, devices, services, activities and associated supplies, not exclusively used for medical purposes.

13. Non-emergency medical transportation.

14. Non-emergency dental restoration.

15. All physical, occupational, speech, cognitive or other restorative therapy or body part manipulation, including follow up evaluations by the referring physician, except that provided for Identified Injuries in accordance with Decision Point Review.

16. Podiatry.

17. Audiology.

18. Bone scans.

19. Computerized muscle testing.

20. Work hardening.

21. Current perceptual testing.

22. Temperature gradient studies.

23. Vax D and DRX.

24. Prescriptions, including but not limited to Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration when prescribed for more than three (3) months or in excess of $50 for a single fill and/or a thirty (30) day supply.

25. Prescriptions for medications that are not approved by the Food and Drug Administration.

26. Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.

27. All pain management treatment and services except that 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) Anesthesia when performed in conjunction with invasive techniques;

    e) Epidural steroid injections;

    f) Radio frequency/rhyzotomy;

    g) Biofeedback;

    h) Implantation of spinal stimulators or spinal pumps;

i) TENS units (transcutaneous electrical nerve stimulation); and

j) Trigger point injections.

Decision Point Review/Precertification requirements shall not apply to diagnostic tests, treatments, prescriptions or DME administered or obtained within ten (10) days of the claimants covered injury. However, such items may be reviewed retrospectively and must be medically necessary and causally related to the covered injury in order to be reimbursable.

DECISION POINT REVIEW/PRECERTIFICATION

During Decision Point Review/Precertification, the treating health care provider has the opportunity to explain any complicating factors that may require additional treatment or provide medical justification for diagnostic testing. Decision Point Review/Precertification will be performed upon receipt of the necessary medical information from the treating provider either by mail or electronic transmission.

The request can be faxed to (908)382-7157 or mailed to the following address:

New Jersey Property-Liability Insurance Guaranty Association
Attention: Precertification Department
233 Mt. Airy Road
Basking Ridge, NJ 07920

Requests sent to any other facsimile number or address will not be considered. Upon receipt of proper written documentation, NJPLIGA will either:

a) Authorize the treatment, diagnostic testing and/or DME;

b) Deny and/or modify the treatment, diagnostic testing and/or DME;

c) Request additional medical documentation; or

d) Advise that an Independent Medical Examination will be scheduled.

If NJPLIGA fails to do at least one of the above four (4) things within three (3) business days after receipt of a request submitted on the appropriate form(s) to the appropriate address or fax number, the proposed treatment, diagnostic testing and/or DME is deemed to be authorized until a final determination is communicated to the treating health care provider. The decision to deny a request based upon medical necessity will be made by a health care provider.

Hours of Operation

The business day is 8:00 a.m. to 4:30 p.m. Note that "business days" do not include Saturdays, Sundays, legal holidays or days that the office is closed due to severe weather, mandatory evacuation or a State of Emergency.

Decision Point Review and Precertification requests must be submitted on the APTP Form approved by the DOBI. The following required information must be submitted to NJPLIGA in order to consider a request for Decision Point Review/Precertification:

1. Provider's name, address, telephone number, contact person and specialty.
2. History of the injury, prior injuries, previous medical history, current clinical findings.
3. ICD (International Classification of Diseases) diagnosis codes related to the injury.
4. Current claimant evaluation including objective clinical findings.
5. Results of completed diagnostic testing.
6. Amount and type of treatment received to date with documented response.
7. Proposed diagnostic tests for comparison to criteria contained in N.J.A.C. 11:3-4.5.
8. Proposed course of treatment consistent with subjective and objective findings.
9. Proposed CPT (Current Procedural Terminology), CDT (Current Dental Terminology), HCPCS (Healthcare Common Procedure Coding System) and procedural codes related to the diagnoses, including frequency and duration. Proper codes must be utilized for medical or dental treatments.
10. Date of re-evaluation for discharge or anticipated discharge date (Decision Point Review).
11. Legible notes.

All requests for surgical procedures require supplemental information. This information should be submitted on the Surgery Precertification Request for NJ PIP Claims Form.

This information will be compared to standards of good practice, standard professional treatment protocols and established practice parameters utilized by NJPLIGA. The medical necessity of proposed diagnostic tests will be evaluated based on the criteria contained in N.J.A.C. 11:3-4.5 and N.J.S.A. 39:6A-2(m).

NJPLIGA will provide its determination within three (3) business days following receipt of a properly submitted request. NJPLIGA's failure to respond within three (3) business days will allow a health care provider to continue treatment until the required determination is provided.

When an improperly submitted request is received, NJPLIGA will inform the treating health care provider what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation or information will be issued and will remain in effect until all requested information required to determine medical necessity regarding the requested treatment, testing and/or DME is received.

Authorized testing, treatment and/or DME is only approved for the range of dates noted in the determination letter(s).

If a treating health care provider fails to follow the procedures listed below, all testing, treatment and/or DME completed after the last date in the range of dates indicated in the determination letter will be subject to a penalty co-payment of fifty percent (50%), even if the services are determined to be medically necessary. In order to avoid this penalty co-payment, treating health care providers must follow the appropriate procedure below:

- When medically necessary care or DME is not completed within fourteen (14) calendar days from the date in which the authorization period expired, a written extension request, including the supporting reason for the extension, must be sent to NJPLIGA. The request can be faxed to (908)382-7157 or mailed to the following address:

New Jersey Property-Liability Insurance Guaranty Association
Attention: Precertification Department
233 Mt. Airy Road
Basking Ridge, NJ 07920

INDEPENDENT MEDICAL EXAMINATIONS

NJPLIGA may request that the claimant attend an Independent Medical Examination ("IME"). If an IME is requested, the claimant will be notified of the appointment within seven (7) calendar days from the date that NJPLIGA notified all required parties that an IME will be scheduled, unless the claimant agrees with NJPLIGA to extend the time period for the scheduling. The IME will be conducted by a health care provider within the same specialty of the treating health care provider and will be conducted at a location reasonably convenient to the claimant. Claimant must attend the IME and cooperate with NJPLIGA to schedule the examination. Failure to do so may jeopardize claimant's future benefits.

If it is necessary for claimant to reschedule the IME appointment, the claimant must contact NJPLIGA for approval at least three (3) business days prior to the scheduled appointment.

Except for non-emergent tests, surgery, procedures performed in ambulatory surgical centers, outpatient facilities and/or hospitals and invasive dental procedures, treatment may proceed while the IME is being scheduled and until the results become available. However, only medically necessary treatment related to the motor vehicle accident will be reimbursed and such treatment is subject to utilization review. If the IME provider prepares a written report concerning the IME, the claimant, or claimant's designee, shall be provided a copy of the report upon request.

The following will result in an unexcused failure to attend the IME:

1. Failure to present photo identification to the IME provider at the time of the examination.

2. Failure to be accompanied by an interpreter (of legal age) if the claimant is non-English speaking. NJPLIGA will not pay for any interpreter fees and/or costs.

3. Failure to attend any of the scheduled examination appointments for any unexcused reason.

4. Failure to provide to the examining physician all available medical records and diagnostic studies/tests before or at the time of the scheduled examination.

5. Failure to obtain approval from NJPLIGA to reschedule at least three (3) full business days prior to the originally scheduled appointment. Approval shall be at the sole discretion of NJPLIGA.

If the claimant has two (2) or more unexcused failures to attend the scheduled IME, notification will be immediately sent to the claimant, or to claimant's designee, and all health care providers treating the claimant. The notification will place the claimant and all treating health care providers on notice that all future treatment, diagnostic testing or DME for the injuries will not be reimbursable as a consequence of failure to comply with the DPR Plan.

Within three (3) business days after the IME is attended, NJPLIGA will notify the claimant and the treating health care provider of the results of the examination. If the results are not provided within three (3) business days of the IME, the treatment, testing and/or the provision of DME in that specialty may proceed until either the claimant and/or the treating health care provider has been notified that reimbursement for the treatment, testing or DME is not authorized.

DUTY TO COOPERATE

A claimant shall, as a condition to obtaining benefits from NJPLIGA, cooperate with NJPLIGA's investigation into all of the facts surrounding the accident and medical/dental treatment including submitting to an examination under oath if so requested, to be conducted by a person designated by NJPLIGA. Such an examination shall be conducted at a time and

location reasonably convenient to the claimant, who shall have the right to be represented by counsel. The examination may be conducted on any subject reasonably related to issues concerning the claimant's eligibility for benefits from NJPLIGA or the reasonableness and necessity of any proposed medical/dental treatment or details regarding medical/dental treatment already rendered or received. A stenographic record shall be made of the examination.

VOLUNTARY UTILIZATION NETWORK

For non-emergency benefits, certain goods and services may be secured through NJPLIGA or its designated Voluntary Utilization Network: Procura Network ("Network"). All of the network partners are part of Procura Management, Inc.'s New Jersey Managed Care Organization ("MCO") certification and meet the requirements of N.J.A.C. 11:3-4.8. These Networks provide excellent service and offer convenient locations throughout the State. In addition, the use of these Networks will allow the claimant's benefit dollars to go further. The following services are available through the Networks:

1. DME with an aggregate cost or monthly rental in excess of $50 including DME and supplies, prosthetics and orthotics.
2. Magnetic resonance imagery.
3. Computer assisted tomography scan.
4. Prescription drugs.
5. Electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)(1)-(3), except for needle EMG's, H-reflex and nerve conduction velocity tests performed together by the treating physician.
6. Services, equipment or accommodations provided by an Ambulatory Surgical Center.

The availability of a Network does not waive the requirement for Decision Point Review and precertification of goods or services as required by this DPR Plan.

Upon notification to NJPLIGA of an injury claim, the claimant or claimant's designee will receive information regarding the DPR Plan including the availability of Voluntary Utilization Network and the penalty assessed for failure to utilize the Network.

In addition, when NJPLIGA receives a request for goods and/or services, the claimant and treating health care provider will receive a Decision Point Review/Precertification determination letter advising the claimant of options available to receive Network services and an explanation of the thirty percent (30%) co-payment penalty that may be assessed for failure to obtain these goods or services from a Network.

A thirty percent (30%) co-payment penalty shall apply if goods or services available through NJPLIGA or its designated Network are not procured through NJPLIGA or its designated Network. This penalty is in addition to any other policy or statutory deductible or offset, co-payment and penalty applicable under this DPR Plan.

For information regarding the available Voluntary Utilization Network, the claimant or claimant's designee and the treating health care provider may access NJPLIGA's website at www.njguaranty.org or call (908)382-7100.

PENALTIES

The co-payment penalties set forth in the DPR Plan are in addition to any other policy or statutory deductible, co-payments or offsets.

Fifty Percent (50%) Co-Payment Penalty

NJPLIGA shall assess a fifty percent (50%) co-payment penalty for medically necessary diagnostic tests, treatments, surgeries (including ancillary services, procedures and facility fees), DME and non-medical products, devices, services and activities that are incurred without first complying with the provisions of this DPR Plan. The treating health care provider's non-compliance with the provisions of this DPR Plan may trigger this additional co-payment penalty. No penalty under this provision will be applied within the first ten (10) days after the accident.

Non-compliance, which shall result in the imposition of a fifty percent (50%) co-payment penalty, includes any of the following:

1. Failure to follow the Precertification requirements of this DPR Plan including the submission of the Surgery Precertification Request for NJ PIP Claims Form when required as specified in this DPR Plan.

2. Failure to follow the Decision Point Review requirements of this DPR Plan.

3. Failure to provide clinically supported findings for medical procedures, treatments, diagnostic tests, services, non–medical products, devices and activities or DME at the time of the request for Decision Point Review/Precertification.

The fifty percent (50%) co-payment penalty shall apply to the eligible charge for medically necessary diagnostic tests, treatments or DME that were provided between the time notification to NJPLIGA was required and the time that proper notification is made and NJPLIGA has an opportunity to respond in accordance with this DPR Plan.

Thirty Percent (30%) Co-Payment Penalty

Non-compliance, which shall result in the imposition of a thirty percent (30%) co-payment penalty, includes any of the following:

1. Failure to secure DME through NJPLIGA or its designated vendor(s) or Network.

2. Failure to secure specified diagnostic imaging/testing through NJPLIGA or its designated vendors(s) or Network.

3. Failure to secure prescription drugs through NJPLIGA or its designated vendor(s) or Network.

4. Failure to secure ambulatory surgery through NJPLIGA or its designated vendor(s) or Network.

INTERNAL APPEAL PROCESS

There are two (2) types of internal appeals:

1. **Pre-Service Appeals** - Treatment appeals about the medical necessity of future treatment or testing that was requested by the treating health care provider on a properly completed Decision Point Review/Precertification request; and

2. **Post-Service Appeals** - Administrative appeals for all other types of adverse decisions, including but not limited to, bill disputes, Precertification penalties and coding discrepancies.

All appeals shall be filed using the appropriate Pre-Service or Post-Service Appeal Forms which are available at www.njguaranty.org or by contacting NJPLIGA at (908)382-7100. All Forms must be completed fully, including the claim number, date of loss, claimant name and clearly identify the adverse decision that is the basis for the appeal. Treatment appeals must specifically explain the reason the treatment request should be reconsidered and, if applicable, provide supporting medical/dental documentation and/or test results that were not submitted with the original request for treatment. It is not necessary to resubmit the documentation previously submitted.

Incomplete or untimely filing of an appeal Form will result in an administrative denial.

Pre-Service Appeal Forms must be faxed to (908)382-7160 and Post-Service Appeal Forms must be faxed to (908)382-7158 or mailed to:

New Jersey Property-Liability Insurance Guaranty Association
Attention: Appeals Department
233 Mt. Airy Road
Basking Ridge, NJ 07920

Appeals sent to any other facsimile number or address will not be considered.

Pre-Service Appeals

Pre-Service Appeals shall be submitted no later than five (5) business days after the treating health care provider has received notice of the adverse decision that is the basis for the appeal. Pre-Service Appeals may not be submitted as administrative appeals. Provided that additional necessary medical information is submitted with the Pre-Service Appeal, NJPLIGA will render a decision within ten (10) business days of receipt of the appeal, unless it is determined that a peer review or an IME is appropriate. The treating health care provider will be notified within ten (10) business days if a peer review or IME is required.

Pre-Service Appeals that are submitted after five (5) business days will be considered untimely. An incomplete or untimely appeal does not constitute an appeal. If a provider misses the deadline to submit a Pre-Service Appeal, he or she may submit another Decision Point Review or Precertification request for the treatment or testing. Submission of information identical to the initial information submitted in support of the treatment request will not be accepted as a request for a Pre-Service Appeal.

Post-Service Appeals

As a condition precedent to filing an arbitration or litigation, a claimant or health care provider who has rendered services and accepted an assignment of benefits must submit a written request for a Post-Service Appeal of any and all disputes, including but not limited to, any claims for unpaid medical bills for medical/dental expenses and for unpaid services not authorized and/or denied in the Decision Point Review and Precertification Process. The request must specify the issue(s) contested and provide supporting documentation. Post-Service Appeals cannot be submitted as treatment appeals.

In order to be considered valid, all Post-Service Appeals must be submitted within one hundred eighty (180) calendar days of the adverse decision and at least thirty (30) calendar days prior to initiating arbitration or litigation. In addition, all requests for Post-Service Appeals must include, as the cover page, a fully completed PIP Post-Service Appeal Form and must be faxed to NJPLIGA at (908)382-7158. This Form is available at www.njguaranty.org or may be obtained by contacting NJPLIGA at (908)382-7100. An incomplete or untimely appeal does not constitute an appeal.

NJPLIGA will render a decision within thirty (30) business days from the date of the appeal. NJPLIGA will not accept or respond to appeals that are sent to any other facsimile number or that fail to include a fully completed PIP Post-Service Appeal Form. Only requests for PIP Post-Service Appeals will be accepted at this number. Requests for Decision Point Review, Precertification or Pre-Service Appeals will not be accepted at this number.

Independent Medical Exam Needed for an Appeal

If it is determined that an IME is necessary to respond to either a treatment or administrative appeal, the time periods to respond to the appeal request shall start after the IME has been conducted and the report received from the examining physician.

After the IME has been conducted and the report has been received, the treating health care provider will be notified, by facsimile, of the decision on Pre-Service Appeals within ten (10) business days or Post–Service Appeals or administrative appeals within thirty (30) business days.

Arbitration

Pursuant to N.J.A.C. 11:3-5.1, any properly submitted appeal that has not been resolved through the Internal Appeal Process may be submitted for personal injury protection dispute resolution to Forthright, the New Jersey No-Fault PIP Arbitration Program. Forthright may be contacted for filing information at (732)271-6100. Forms, rules and procedures are also available on Forthright's website at http://www.nj-no-fault.com/. The claimant or treating health care provider agrees to indemnify and hold NJPLIGA harmless for any legal fees and/or costs incurred by NJPLIGA as a result of the claimant and/or treating health care provider's failure to utilize the Internal Appeal Process prior to filing with Forthright.

To the extent permitted by law, the results of the Forthright arbitration filing shall be final and binding, with no right of appeal.

Assignment of Benefits

A treating health care provider must obtain an executed assignment of benefits to be paid directly by NJPLIGA for covered services. A copy of this assignment agreement must be furnished to NJPLIGA upon request. As a condition of assignment, the treating health care provider must follow the requirements of this DPR Plan and shall hold the claimant harmless for penalty co-payments imposed by NJPLIGA based upon the treating health care provider's failure to follow the requirements of the NJPLIGA DPR Plan. Failure to comply with (1) the NJPLIGA DPR Plan requirements; or (2) the requirement to comply with the Internal Appeal Process at least thirty (30) calendar days prior to initiating arbitration or litigation will render any prior assignment of benefits under this Plan null and void.