

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

Please read this information carefully and share it with your health care providers.

This notice informs claimant and/or claimant's health care provider pursuant to a Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements 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 waiver by NJPLIGA of any provision contained in this DPR Plan shall not be deemed to constitute a waiver of any other provisions contained herein. The failure of NJPLIGA to enforce any of the provisions contained in this DPR Plan shall not be construed as a waiver of the right of NJPLIGA thereafter to enforce any such provisions.

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. The DPR Plan is also available by calling NJPLIGA's managed care services vendor, Optum Managed Care Services, ("Optum") at (800) 275-9485 or by going to the Optum website at www.procura-inc.com.

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 Optum 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, United States Food and Drug Administration ("USFDA") approved prescription medication, 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) days¹ 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, USFDA approved prescription medication or DME, a co-payment of fifty percent (50%) will apply even if the services are determined to be medically necessary and causally related to the accident. Optum 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. Optum will provide Decision Point Review, Precertification and other medical management services as permitted under New Jersey law, rules and regulations.

Optum will be available from 7:30 a.m. to 5:00 p.m., Monday through Friday, to respond to provider Decision Point Review and Precertification requests and inquiries by phone (800) 275-9485 or facsimile (610) 631-7011. Voicemail will be activated for messages received on weekends, holidays and before or after hours and will be handled on the next business² day.

DIAGNOSTIC TESTING

The following diagnostic tests are subject to Decision Point Review:

1. Brain mapping
2. Brain audio evoked potentials ("BAEP")
3. Brain evoked potentials ("BEP")
4. Computer assisted tomograms ("CT", "CAT" scan)

¹ "Days" is defined as calendar days unless specifically designated as "business days" in this DPR Plan. A calendar day ends at the close of business hours. The day a request or any other communication is received by NJPLIGA or Optum, where applicable, is not counted when calculating the number of days.

² "Business day" is defined as Monday through Friday, 7:30 a.m. to 5:00 p.m., p.m., not including Saturdays, Sundays, State or Federal holidays or days that the office is closed due to severe weather, mandatory evacuation or a State of Emergency. The day a request or any other communication is received by NJPLIGA or Optum, where applicable, is not counted when calculating the number of days.

5. Dynatron/cybex station/cybex studies
6. Video fluoroscopy
7. H-reflex studies
8. Sonogram/ultrasound
9. Needle electromyography (needle “EMG”)
10. Nerve conduction velocity (“NCV”)
11. Somatosensory evoked potential (“SSEP”)
12. Magnetic resonance imaging (“MRI”)
13. Electroencephalogram (“EEG”)
14. Visual evoked potential (“VEP”)
15. Thermogram/thermography
16. 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:

1. Spinal diagnostic ultrasound
2. Iridology
3. Reflexology
4. Surrogate arm mentoring
5. Surface electromyography (surface EMG)
6. Mandibular tracking and stimulation
7. X-ray digitization and/or computer assisted radiographic mensuration
8. 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):

1. Mandibular tracking
2. Surface EMG
3. Sonography
4. Doppler ultrasound
5. Needle EMG
6. Electroencephalogram (“EEG”)
7. Thermograms/thermographs
8. Videofluoroscopy
9. Reflexology

NJPLIGA will also not provide reimbursement for the following:

1. Laboratory testing services from any entity that has not obtained the appropriate state and/or federal accreditations and/or certifications to perform testing on human specimens.
2. Laboratory testing services in excess of the calculated payment rates as defined in the Medicare claims processing manuals for laboratory services and in accordance with accepted laboratory coding standards.
3. Prescription medications, drugs and biologicals that are not approved by the USFDA.
4. Compound prescription medications, drugs and/or biologicals that, as compounded, are not approved by the USFDA, including but not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.
5. NJPLIGA has no obligation to reimburse for specific CPT/HCPC codes, even if those codes are pre-certified through a Decision Point Review or Precertification request as being medically necessary and causally related to the accident, if the DOBI has adopted payment adjudication methodologies in the NJ PIP regulations that consider those charges not to be reimbursable. These payment adjudication methodologies include, but are not limited to, the NCCI edits and other Medicare guidelines. The link to DOBI’s interpretation of the auto medical fee schedule can be viewed at the DOBI’s website. A link to the DOBI’s website is also accessible from the NJPLIGA website, www.njguaranty.org. The current NCCI edits can be obtained from the Center for Medicare and Medicaid Services website. A link to the Center for Medicare and Medicaid Services website is also accessible from the NJPLIGA website, www.njguaranty.org.

NOTIFICATION REQUIREMENTS

Upon receiving notification of a claim, NJPLIGA will investigate the matter and take the necessary steps to protect our mutual interests with the understanding that NJPLIGA does so under a complete reservation of rights. NJPLIGA reserves all

rights and defenses available to it pursuant to applicable statutes, rules, regulations and this DPR Plan (collectively “NJPLIGA’s Rights”). Any action that NJPLIGA may take in the investigation or defense of a claim is not to be construed as a waiver of NJPLIGA’s Rights. NJPLIGA reserves the right to alter or amend its determinations should additional information be provided to NJPLIGA as part of its investigation or in the course of handling a particular claim.

Failure to timely provide NJPLIGA with information as part of its investigation prejudices NJPLIGA’s ability to timely complete its investigation and manage the medical care of those claims that satisfy eligibility requirements. Any person who knowingly files a statement of claim containing any false or misleading information or intentionally omits information material to the claim is subject to criminal and civil penalties.

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 a Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements form. Information will be provided on how to contact NJPLIGA or Optum, where applicable. 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, USFDA approved prescription medication, DME and non-medical products, devices, services and activities identified below, the claimant’s treating health care provider is required to obtain Precertification from Optum. Decision Point Review/Precertification requests must be submitted on the Attending Provider Treatment Plan (“AFTP”) 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. The form is also available by calling Optum at (800) 275-9485.

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 and the need for and names of co-surgeons 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 shall be submitted on or with the Surgery Precertification Request for NJ PIP Claims Form which is available at www.njguaranty.org or by contacting Optum. 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 Optum in support of a Decision Point Review or Precertification request must be clinically supported and establish that prior to selecting, performing or ordering the administration of a treatment, diagnostic test, USFDA approved prescription medication 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, USFDA approved prescription medication 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, USFDA approved prescription medication or DME; and
4. Recorded and documented those observations, positive and negative findings and conclusions on the claimant’s medical records.

MANDATORY PRECERTIFICATION:

Precertification by Optum is not a guaranty of payment and, as such, shall not be used in any forum or venue including arbitration, alternative dispute resolution or court to imply, infer or indicate that payment should be made.

Mandatory Precertification applies to the following:

1. Non-emergency inpatient and outpatient hospital care including ancillary services and products, procedures and facility fees (Precertification request must include the necessity and duration of the hospital stay).
2. Non-emergency surgical procedures or surgery (performed in a hospital, ambulatory surgical facility or office) including ancillary services, products, procedures, facility fees, implants and post-operative care and/or supplies not included in the global fee period. The Precertification request must include the necessity for the procedure and the anticipated duration of the stay. 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.
3. Non-emergency inpatient and outpatient psychological/psychiatric services and/or testing including biofeedback.
4. Infusion therapy.
5. Extended care, skilled nursing and rehabilitation facilities/services.
6. 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.
7. Treatment, testing and/or DME relating to temporomandibular disorders and/or any oral facial syndrome.
8. Carpal tunnel syndrome.
9. All home healthcare.
10. DME with an aggregate cost or monthly rental in excess of \$75.00 and/or monthly rental greater than thirty (30) days including DME and associated supplies, prosthetics and orthotics.
11. Non-medical products, devices, services, activities and associated supplies, not exclusively used for medical purposes or as DME with an aggregate cost or monthly rental in excess of \$75.00.
12. Non-emergency medical transportation.
13. Non-emergency dental restoration.
14. 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.
15. Podiatry.
16. Audiology.
17. Bone scans.
18. Computerized muscle testing.
19. Work hardening.
20. Current perceptual testing.
21. Temperature gradient studies.
22. Vax D and DRX.
23. Psychological testing.
24. Interoperative neuromonitoring.
25. Videonystagmography ("VNG"), nystagmus, vestibular, balance or cognitive testing.
26. CAT/myelogram
27. Discogram
28. 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) times in a row, for a time period of more than ninety (90) days, or more than three (3) times in one (1) year or in excess of \$75.00 for a single fill and/or a thirty (30) day supply.
29. Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.
30. 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);
 - j) PENS units (percutaneous electrical nerve stimulation);
 - k) Electro-acupuncture devices; and
 - l) Trigger point injections.

31. Non-emergency drug screening and/or drug testing, including but not limited to any technical analysis of urine, hair, blood, breath, sweat, saliva or other biological specimen used to detect the presence or absence of specified drugs or their metabolites, controlled substances, alcohol or drugs prohibited by law.

Decision Point Review/Precertification requirements shall not apply to diagnostic tests, treatments, USFDA approved prescription medications or DME administered or obtained within ten (10) days of the claimant's 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.

VOLUNTARY PRECERTIFICATION

Claimant and claimant's treating health care provider are encouraged to participate in a Voluntary Precertification process by providing a comprehensive treatment plan for both identified and other injuries. An approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification at Decision Points and for Treatment, Diagnostic Testing or DME requiring precertification is not required.

DECISION POINT REVIEW/PRE CERTIFICATION

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 by facsimile to (610) 631-7011. You may also submit your requests via the website: <http://providerhub.procuranet.com>, the following e-mail address: AIMSAdmin@optum.com, or the following mailing address:**

**Optum Managed Care Services
2500 Monroe Boulevard, Suite 100
Norristown, PA 19403**

Requests sent to any other destination will not be considered. Upon receipt of proper written documentation, Optum will either:

- a) Authorize the treatment, diagnostic testing, USFDA approved prescription medication and/or DME;
- b) Deny and/or modify the treatment, diagnostic testing, USFDA approved prescription medication and/or DME;
- c) Request additional medical documentation; or
- d) Advise that an Independent Medical Examination will be scheduled.

If Optum fails to do at least one (1) 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 facsimile number, the proposed treatment, diagnostic testing, USFDA approved prescription medication 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 7:30 a.m. to 5:00 p.m., Monday through Friday. Note that "business days" do not include Saturdays, Sundays, State or Federal holidays or days that the office is closed due to severe weather, mandatory evacuation or a State of Emergency. The day a request or any other communication is received by Optum is not counted when calculating the number of business days.

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 Optum 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, with the exception of minor surgery,³ require supplemental information. This information should be submitted on or with 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 Optum. 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).

Optum will provide its determination within three (3) business days following receipt of a properly submitted request. Optum'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, Optum 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, USFDA approved prescription medication and/or DME is received and a determination is rendered in accordance with this DPR plan.

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, USFDA approved prescription medication 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 and causally related to the accident. In order to avoid this penalty co-payment, treating health care providers must submit to NJPLIGA a written extension request, including the supporting reasons for the extension, when medically necessary and causally related treatment, diagnostic testing, USFDA approved prescription medication or DME is not completed within fourteen (14) days from the date in which the authorization period expired.

The request may be sent by facsimile to (610) 631-7011. You may also submit your requests via the website: <http://providerhub.procuranet.com>, the following e-mail address: AIMSAdmin@optum.com, or the following mailing address:

**Optum Managed Care Services
2500 Monroe Boulevard, Suite 100
Norristown, PA 19403**

Requests sent to any other destination will not be considered.

INDEPENDENT MEDICAL EXAMINATIONS

NJPLIGA and/or Optum 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 and/or Optum notified all required parties that an IME will be scheduled, unless the claimant and NJPLIGA and/or Optum mutually agree 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 or by a board certified specialist with the requisite expertise in the area of

³ Pursuant to N.J.A.C. 13:35-4A.3 "minor surgery" means surgery which can safely and comfortably be performed on a patient who has received no more than the maximum manufacturer recommended dose of local or topical anesthesia, without more than minimal pre-operative medication or minimal intra-operative tranquilization and where the likelihood of complications requiring hospitalization is remote. Minor surgery specifically excludes all procedures performed utilizing anesthesia services as defined in this section. Minor surgery also specifically excludes procedures which may be performed under local anesthesia, but which involve extensive manipulation or removal of tissue such as liposuction or lipo-injection, breast augmentation or reduction, and removal of breast implants. Minor surgery includes the excision of moles, warts, cysts, lipomas, skin biopsies, the repair of simple lacerations, or other surgery limited to the skin and subcutaneous tissue. Additional examples of minor surgery include closed reduction of a fracture, the incision and drainage of abscesses, certain simple ophthalmologic surgical procedures, such as treatment of chalazions and non-invasive ophthalmologic laser procedures performed with topical anesthesia, limited endoscopies such as flexible sigmoidoscopies, anoscopies, proctoscopies, arthrocenteses, thoracenteses and paracenteses. Minor surgery shall not include any procedure identified as "major surgery" within the meaning of N.J.A.C. 13:35-4.1.

medicine for which a test or treatment has been requested or a diagnosis has been rendered and will be conducted at a location reasonably convenient to the claimant.

Claimant must attend the IME and cooperate with NJPLIGA and/or Optum to schedule the examination. Claimant must bring valid photo identification to the IME. If claimant is non-English speaking, an interpreter of legal age must accompany the claimant to the IME. NJPLIGA and/or Optum will not provide an interpreter or reimburse for this expense. Claimant must bring copies of all medical records and diagnostic studies related to claimant's injury to the IME. Claimant must fully cooperate with the examining physician and may be asked to bring specific prescribed DME items to 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 Optum for approval at least three (3) business days prior to the scheduled appointment by phone at (800) 275-9485 or facsimile (610) 631-7011. Approval to excuse attendance of a scheduled IME appointment and to reschedule the IME shall be at the sole discretion of NJPLIGA or its authorized agent(s).

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 the IME 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 IMEs, 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, USFDA approved prescription medication 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, Optum 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, USFDA approved prescription medication 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, USFDA approved prescription medication or DME is not authorized.

DUTY TO COOPERATE

Claimant shall, as a condition to obtaining benefits from NJPLIGA, cooperate with NJPLIGA's investigation including, but not limited to, providing additional documentation, records or other items requested, written or recorded statements and examinations under oath ("EUOs") on any subjects reasonably related to or having nexus⁴ to the claim being presented. As often as reasonably required by NJPLIGA, EUOs shall be conducted, not in the presence of any other claimants and/or health care providers, by a person designated by NJPLIGA even if statements or EUOs were previously obtained from the aforementioned parties. Such EUOs shall be conducted at times and locations reasonably convenient to the claimant who shall have the right to be represented by counsel. NJPLIGA will not reimburse the claimant for attendance at the EUOs, attorneys' fees or any other expenses related to the EUOs. A stenographic record shall be made of the EUOs and claimant shall subscribe to same.

VOLUNTARY UTILIZATION NETWORK (VUN)

For non-emergency benefits, certain goods and services may be secured through NJPLIGA or its designated Voluntary Utilization Network: Optum Network ("Network"). All of the Network partners are part of Optum Network's certification

⁴ "Nexus" is defined as a point of causal intersection, link, reasonable relation or connection.

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 \$75.00 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.
7. Laboratory testing services.

The availability of the 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 the Voluntary Utilization Network and the penalty assessed for failure to utilize the Network.

In addition, when NJPLIGA and/or Optum receives a request for goods and/or services, the claimant and/or claimant's treating healthcare provider will receive a Decision Point Review/Precertification determination letter advising of the 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 the 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. The thirty percent (30%) co-payment shall not apply to the failure to obtain laboratory testing services through the VUN.

For information regarding the available Voluntary Utilization Network or Prescription Drug network the claimant, claimant's designee and/or claimant's treating health care provider may access NJPLIGA's website at www.njguaranty.org or call (908) 382-7100. **Information regarding the available Voluntary Utilization Network is also obtainable at www.procurainc.com or by calling (800) 275-9485. Information regarding the Prescription Drug network is available at www.cypresscare.com or by calling (800) 419-7191.**

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, USFDA approved prescription medications, 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, USFDA approved prescription medications 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, USFDA approved prescription medications or DME that were provided between the time notification to Optum

was required and the time that proper notification is made and Optum 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, Decision Point Review/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, or Optum at (800) 275-9485. 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 may be sent by facsimile to (610) 631-7011. You may also submit your Pre-Service Appeal requests via the website: <http://providerhub.procuranet.com>, the following e-mail address: AIMSAdmin@optum.com, or the following mailing address:

Optum Managed Care Services
2500 Monroe Boulevard, Suite 100
Norristown, PA 19403

Pre-Service Appeals sent to any other destination will not be considered.

Post-Service Appeal Forms must be sent by facsimile to (908) 382-7158. Post-Service Appeals sent by any other means or to any other facsimile number will not be considered.

Pre-Service Appeals

Pre-Service Appeals shall be submitted **no later than thirty (30) calendar 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, Optum will render a decision within fourteen (14) calendar days of receipt of the pre-service appeal form and all necessary supporting documentation, unless it is determined that a peer review or an IME is appropriate. The treating health care provider will be notified within fourteen (14) calendar days if a peer review or IME is required.

Pre-Service Appeals that are submitted after thirty (30) calendar 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 a Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements 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 ninety (90) calendar days** of the adverse decision **and at least forty five (45) 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 sent by facsimile to NJPLIGA at (908) 382-7158. Only requests for 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. 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) calendar days from the date of the appeal. NJPLIGA will not accept or respond to appeals that are sent to any other facsimile number or by any other method or that fails to include a fully completed PIP Post-Service Appeal Form. Only requests for PIP Post-Service Appeals will 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. New Jersey has an assigned administrator of the New Jersey PIP dispute resolution process pursuant to N.J.S.A. 39:6A-1 et seq. When the DOBI changes the administrator of the PIP dispute resolution process, information about the new administrator is available on the DOBI web site and this DPR Plan shall remain in full force and effect. **Information regarding the administrator of the New Jersey PIP dispute resolution process can be obtained from <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm>. The administrator may be contacted directly for filing information, forms, rules and procedures related to arbitration.** 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 an arbitration.

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

Conditional Assignment of Personal Injury Protection Benefits & Disclosure Requirements (“Conditional Assignment”)

As a condition of assignment of claimant's benefits:

1. A treating health care provider must obtain a fully executed Conditional Assignment in order to be paid directly by NJPLIGA for covered services. NJPLIGA's CONDITIONAL ASSIGNMENT OF PERSONAL INJURY PROTECTION BENEFITS & DISCLOSURE REQUIREMENTS form is the only valid assignment of benefits. A copy of this Conditional Assignment must be furnished to NJPLIGA and/or Optum upon request.
2. The Conditional Assignment must be signed by the claimant and the treating health care provider or an agent authorized to act on behalf of the provider. By executing the Conditional Assignment, or having it executed, the treating health care provider agrees to be bound by the terms of the Assignment and other applicable terms, conditions and duties as set forth in all applicable statutes, rules, regulations and NJPLIGA's DPR Plan. The treating health care provider agrees that NJPLIGA has the right to reject, terminate or revoke the Conditional Assignment at any time.
3. Consistent with N.J.S.A. 39:6A-13(b), N.J.S.A. 17:33A-1 et seq., or other applicable law, the treating health care provider agrees to the production and inspection of documents, objects and facilities reasonably relevant to or having nexus to the claim being presented. This includes but is not limited to:
 - a. Allowing and providing NJPLIGA or its agent(s) with the authority to inspect original documents and credentialing reasonably relevant to or having nexus to the claim being presented that are in the possession of the treating health care provider, its agent(s), or which can be obtained by the treating healthcare provider or its agent(s) using reasonable efforts.
 - i. Inspections will be made during mutually convenient times but within thirty (30) days of any such request;

- ii. Upon mutual agreement, the inspection of documents may be waived by NJPLIGA if copies are provided within thirty (30) days of any such request and the copies are determined to be suitable by NJPLIGA for the purposes of its investigation.
 - b. Allowing NJPLIGA or its agent(s) to verify by inspection of the premise(s), or other location(s) where any professional services and/or treatment or therapy were rendered that the equipment in such premise(s) or location(s) matches the services billed. Such inspections will be conducted at a mutually convenient time and date within thirty (30) days of any such request.
4. The treating health care provider agrees to cooperate with any investigation conducted by NJPLIGA including, but not limited to, providing interviews, written or recorded statements and EUOs on any subjects reasonably related to or having nexus to the claim being presented. As often as reasonably required by NJPLIGA, EUOs shall be conducted, not in the presence of any other claimants and/or health care providers, by a person designated by NJPLIGA, even if statements or EUOs were previously obtained from the aforementioned parties. Such EUOs shall be conducted at times and locations reasonably convenient to the treating health care provider who shall have the right to be represented by counsel. NJPLIGA will not reimburse the treating health care provider for attendance at the EUOs, attorneys' fees or any other expenses related to the EUOs. A stenographic record shall be made of the EUOs and the treating health care provider shall subscribe to same.
5. The treating health care provider acknowledges that Decision Point Review/Precertification by NJPLIGA and/or Optum is only a determination of medical necessity and is not a guaranty of payment. Decision Point Review/Precertification does not confirm or verify eligibility for coverage, statutory benefits or payment. Decision Point Review and Precertification by NJPLIGA and/or Optum shall not be used in litigation in any forum, venue or court proceeding to imply, infer or indicate that payment should be made except as to an issue of medical necessity.
6. The treating health care provider agrees to hold harmless the claimant and NJPLIGA and/or Optum for any reduction of benefits caused by the provider's failure to fully comply with the terms and conditions of the DPR Plan.
7. The treating health care provider irrevocably agrees to follow NJPLIGA's and/or Optum internal appeals processes, where applicable and to exhaust such processes prior to submitting any unresolved disputes through the New Jersey PIP dispute resolution system pursuant to N.J.S.A. 39:6A-1 et seq.