

Palisades Property and Casualty Insurance Company

DECISION POINT REVIEW & PRE-CERTIFICATION PLAN

This notice informs you of your rights and obligations under the decision point review /pre-certification and other related provisions of your automobile policy if you experience a covered loss involving personal injury to you or a family member. We strongly recommend that you carefully read this notice and discuss any questions that you may have with your agent.

Please be advised that if you are injured in an automobile accident you must report the loss to us as soon as reasonably possible. Failure to report the loss to us within 30 days after the automobile accident may result in a reduction in the amount of reimbursement of your medical expenses.

DECISION POINT REVIEW

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, identified as *Care Paths*, for soft tissue injuries of the neck and back, collectively referred to as the *Identified Injuries*. N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests. The Care Paths provide that treatment be evaluated at certain intervals called *Decision Points*. At decision points, you or your health care provider must provide us information about further treatment you or your provider intends to pursue (**Decision Point Review**). This is called *Decision Point Review*. *Treatments that vary from the Care Paths shall be reimbursable only when warranted by reason of medical necessity.*

Failure to provide Palisades Property and Casualty Insurance Company (PPCIC) prior notice of treatment or testing in keeping with Decision Point Review, will be subject to a 50% co-payment, even if care is deemed medically necessary. Failure to request decision point review or precertification, where required, or failure to provide clinically supported findings 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 the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

The Care Paths, accompanying rules and Attending Provider Treatment Plan form are available on the Internet at the Department's website at <http://www.nj.gov/dobi/aicrapg.htm>

Our comprehensive Decision Point Review/Pre-certification Plan is available on our website at www.palisades.com or contacting your agent.

Tests Which Require Decision Point Review (all diagnoses):

- Brain Audio Evoked Potentials (BAEP)
- Brain Evoked Potentials (BEP)
- Brain Mapping
- Computer Assisted Tomograms (CT, CAT Scan)
- Dynatron/ cybex station/cyber studies
- Electroencephalogram (EEG)
- H-Reflex Studies

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- **Magnetic Resonance Imaging (MRI)**
- **Needle Electromyography (EMG)**
- **Nerve Conduction Velocity (NCV)**
- **Somatosensory Evoked Potential (SSEP)**
- **Sonogram/Ultrasound**
- **Thermography for RSD**
- **Videofluoroscopy**
- **Visual Evoked Potential (VEP)**
- **And any other tests as required by N.J.A.C. 11:3-4.5**

PRE-CERTIFICATION PLAN

If the injury is not an *Identified Injury*, you or your providers are required to obtain pre-certification for the services listed below. If you fail to pre-certify such services, payment of your bills may be subject to a penalty co-pay even if the services are determined to be medically necessary.

The following treatments, services, diagnoses and goods require authorization and pre-certification, unless they are part of a previously approved treatment plan:

- **Acupuncture**
- **All non-emergency surgical procedures.**
- **All Pain management services, except that provide for Identified Injuries in accordance with decision point review.**
- **Out-patient Psychological/Psychiatric Services & Testing.**
- **Temporal Mandibular Disorder /Temporal Mandibular Joint**
- **Physical, Occupational, Speech, Cognitive Therapy or other Restorative Therapy, or therapeutic or body part Manipulation including Manipulation under Anesthesia, except that as provided for Identified Injuries in accordance with Decision Point Review.**
- **Neuropsychological Testing**
- **Durable Medical Equipment (including orthotics and prosthetics) costing in excess of \$50 monthly**
- **Home Health Services**
- **Non-Emergency in-patient Hospital care.**
- **Admissions to Rehabilitation, Sub-AcuteCare, Nursing Homes, Convalescent and/or Transitional Living or Residential Care**
- **Carpal Tunnel Syndrome**

Payment for medically necessary services performed without notifying Palisades as required by our pre-certification plan may not be covered and/or may be subject to a penalty co-payment.

Care obtained in an **emergency situation and/or during the first 10 days following the covered loss**, is not subject to decision point review/pre-certification requirements. Immediate care performed by a licensed health care provider during the first ten days following the covered loss including initial office visit with the health care providers, diagnostic testing, and services are subject to retrospective review for medical necessity.

VOLUNTARY COMPREHENSIVE PRE-CERTIFICATION

You and/or your health care provider are strongly encouraged to participate in an agreed upon Voluntary Comprehensive Pre-Certification 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 plan, additional notification to PPCIC at Decision Points or Pre-Certification is **not** required until the expiration of the designated approval period of the plan.

Voluntary comprehensive treatment plan also applies to catastrophic case management provided by PPCIC.

Contact Us:

Palisades Property and Casualty Insurance Company may be contacted by **phone** at 1-732-378-4500 (**fax:** 732-761-0436) or at P.O. Box 818, Farmingdale, NJ 07727. Regular business hours are Monday-Friday, 9:00 a.m. to 5:00 p.m.

PPCIC employs a N.J. State plenary licensed physician as Compliance and Medical Quality Improvement Officer to oversee services provided in accordance with N.J.A.C. 11:3-4.7. Our Dental Director is a Dentist licensed by the state of NJ. Any decision to deny medical treatment, diagnostic tests or durable medical equipment will be made by a physician or dentist.

Your medical provider must submit your name, policy number, date of accident, dates of previous treatment, office notes, diagnoses, diagnostic tests performed and the results, recommended tests, pre-existing conditions, prior medications used, and any additional information requested by PPCIC. Failure to submit the required documentation could delay a decision on your pre-certification/decision point review request and/or result in a denial of your request. All requests must be submitted on the Attending Provider Treatment Plan form.

Our review of decision point/pre-certification requests and/or comprehensive treatment plan will be completed within 3 business days of receipt of the necessary information. PPCIC shall respond to your provider in writing as to whether or not the medical documentation supplied by your treating provider is sufficient and consistent with normal standards of care. If we fail to notify you or your provider within 3 business days, you may continue with the test or treatment until final determination is communicated to you or your provider. However, all services performed during that time are subject to retrospective review for causality. An insurer shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless the request involved fraud or misrepresentation, as defined in N.J.A.C. 11:16-16.2. by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

In addition, PPCIC may request that you attend an independent physical examination. If an independent physical examination is requested, the examination will be scheduled within 7 calendar days of receipt of the decision point/pre-certification request, unless you agree with us to extend the time period. The independent physical examination will be conducted by a health care provider within the same specialty as your treating health care provider and will be conducted in a location reasonably convenient to you. You must, upon our request, or the request of PPCIC, provide medical records and other pertinent information to the health care provider conducting such physical examination. The requested records shall be provided before or at the time of the examination. Repeated unexcused failure to attend a scheduled physical examination will result in denial of further treatment for the diagnosis, diagnostic testing, or durable medical equipment for the diagnosis and related diagnosis. After your second unexcused failure to attend your scheduled physical examination, notification will be sent to you, with a copy to your treating health care provider(s), that no further treatment, diagnostic testing, or durable medical equipment for the diagnosis will be paid by us. In addition your failure to provide medical records including diagnostic tests will be considered one (1) unexcused failure. In order to avoid unexcused failures to appear for an independent physical examination, you must notify PPCIC no later than 72 hours before the scheduled time of the examination, that you are unable to attend, along with an explanation of your inability to attend. If transportation is a problem, please speak to the IME coordinator, or to the PPCIC claims adjuster to obtain assistance. Lack of transportation will not be considered an excused absence. Results of the independent physical examination and the determination regarding your pre-certification request will be submitted to your health care provider within 3 business days after the examination. Please note that your treatment may proceed while the independent physical examination is being scheduled and until the results are available unless previously denied by Decision Point Review or Pre Certification Review. However, all services performed during that time are subject to retrospective review for causality.

Unless otherwise indicated, all determinations regarding decision point review and pre-certifications from PPCIC will be provided in writing within 3 business days of the examination. If the examining health care provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

Notwithstanding the preceding paragraphs regarding decision point/precertification, please be advised that you have a duty to cooperate under the terms and conditions of the Palisades Property and Casualty Insurance Company policy. Therefore, PPCIC reserves the right to deny or disclaim coverage due to your failure to cooperate.

VOLUNTARY NETWORKS

Your policy carries a statutory minimum \$250 deductible and 20% co-pay per accident, up to \$5,000 in allowable charges.

Additionally, your policy carries a 30% co-payment up to the eligible charge for Durable Medical Equipment exceeding \$50 and for the following Diagnostic tests:

- **Magnetic Resonance Imagery (MRI)**
- **Cat Scan**
- **Needle Electromyography (EMG) except when performed by the treating physician***
- **Somatosensory evoked potential (SSEP)**
- **Electroencephalogram (EEG)**
- **Visual evoked potential (VEP)**
- **Brain audio evoked potential (BAEP)**
- **Brain evoked potential (BEP)**
- **Nerve conduction velocity (NCV)**
- **H-reflex study**
- **Durable Medical Equipment with a cost or monthly rental exceeding \$50.00**
- **Prescription Drugs**
- **Your treating health care provider may perform this electrodiagnostic testing and other electrodiagnostic testing in conjunction with a Needle Electromyography (Needle EMG) which is medically necessary and clinically supported. An out of network penalty will not apply in this situation.**

Your co-payment for prescription drugs is \$10.

If at any time during treatment, an eligible injured person seeks services, testing and/or durable medical equipment and **voluntarily** obtains these services and supplies from a conveniently located, pre-approved network identified through PPCIC, the 30% co-payment for the tests or equipment will be waived.

The \$10 prescription co-payment will be waived on related prescription drugs if obtained from a pharmacy network identified by PPCIC with locations throughout the state.

In addition, PPCIC offers a voluntary network for physical therapy and rehabilitative services, including rehabilitation and sub-acute care facilities. The use of these services through the voluntary network, may extend your benefit dollars and assure quality care. Use of these services is **voluntary** and failure to use them **will not be subject to a co-payment.**

PENALTY

If you are injured in an automobile accident you must report the loss to us as soon as reasonably possible. Failure to report the loss to us within 30 days after the accident may result in an additional co-payment of up to 25% when reported 30 or more days after the accident and up to 50% if notice of your injury is not reported to us 60 or more days after the accident.

Failure to request decision point review or precertification where required or failure to provide clinically supported findings 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 necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

INTERNAL APPEAL PROCESS

Your provider can request an Internal Appeal on any or all issues and disputes regarding the treatment plan, pre-certification of treatment of services, testing or denied services or other matters related to treatment and care of an injured person. Medical Directors are available to discuss the appeal with the treating provider.

Appeal requests must be submitted within 30 days of the adverse determination, along with clinically supported documentation. If necessary, PPCIC may request additional medical records or documentation. A determination of your appeal will be provided within 14 business days. If further documentation is required, a determination will be provided within an additional 14 business days of receipt of such documentation.

If an expedited appeal is requested for prospective care, PPCIC's Medical Director will review the matter promptly and provide an answer within 3 business days.

In addition, if your provider has accepted an assignment of benefits then your provider must agree to utilize the Internal Appeals Process prior to submitting the matter to a dispute resolution process pursuant to N.J.A.C. 11:3-5. If after the Internal Appeals Process has been exhausted and a dispute still exists you or your provider may submit the matter to Alternate Dispute Resolution.

ASSIGNMENT OF BENEFITS

Your policy governs the manner in which Personal Injury Protection benefits can be assigned to a provider of service benefits. In order for an assignment of benefits to be valid, we must consent in writing to the assignment and the following conditions must be met:

- a. We must be provided with prompt notice of a claim;
- b. We must receive all required applications and forms;
- c. We must receive a signed affidavit of no insurance, if applicable; and
- d. All of the terms and conditions of your High Performance Policy (HPP) must be strictly adhered to.

In addition to the foregoing, our written consent to an assignment of benefits is further conditioned on the provider adhering to the following:

- a. Provide us with prompt notice of the commencement of treatment of our insured;

- b. Adhere to all of the terms and conditions of the High Performance Policy, this Decision Point Review / Pre-certification Plan and all other applicable laws and regulations; and
- c. Provide us with complete medical notes and records when requested to do so.

If an assignment is made by you, approved by us and accepted by your provider of the assigned service benefits your provider shall hold you harmless for any deduction or declination in benefits caused by your provider's failure to comply with the requirements of our Decision Point Review/Pre-Certification Plan and the terms of this policy. In addition, your provider must agree to utilize the Internal Appeals Process prior to submitting the matter to dispute resolution process pursuant to N.J.A.C. 11:3-5. If after the Internal Appeals Process has been exhausted and a dispute still exists you or your provider may submit the matter to the dispute resolution process.

A declination or deduction of benefits will occur in accordance with the terms and conditions of your policy, including but not limited to the following circumstances:

- Coverage is not afforded under this policy;
- You do not attend required Independent Physical Examinations;
- You or your provider of service benefits does not submit to an Examination Under Oath;
- Your provider of service benefits fails to notify us upon the commencement of medical treatment resulting from a covered loss in accordance with New Jersey law and regulation;
- Your provider of service benefits does not comply with requests for medical notes, records, test results or any other information required to be provided to us pursuant to the terms and conditions of this policy;
- You or your provider of service benefits does not comply with all the requirements, duties and conditions, of the Policy, including but not limited to Pre-Certification, Decision Point Reviews or duties of cooperation following an accident or loss; or
- As a result of any fraudulent activity on the part of you or your provider of service benefits.