Important Notice to Policyholders – Medical Protocols
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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 neck and back, collectively referred to as identified injuries.¹

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, insured persons or their health care providers must provide us with information about further treatment the provider intends to pursue. This is called decision point review. Our Decision Point Review Plan and the Care Paths and accompanying rules are available in hard copy by calling us at 1-855-243-1331. To view online, our Decision Point Review Plan is available by logging into your policy at http://www.progressive.com. The Care Paths and accompanying rules are available on the New Jersey Department of Banking and Insurance website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm.

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)
- Dynatron/Cybex Station/Cybex Studies
- Videofluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography
- 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

¹ Terms in bold are defined terms in the insurance policy contract.
For treatment of injuries other than an **identified injury** (soft tissue injury of the neck or back), **insured persons** or their **health care providers** are required to obtain **precertification** for all of the services listed below. If you or your providers fail to **precertify** such services, or fail to provide **clinically supported** findings that support the treatment, diagnostic tests or durable medical equipment requested, payment of bills will be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary. The following treatments, services, goods and **non-medical expenses** require **precertification**, unless they are part of a previously approved treatment plan.

- Non-emergency inpatient and outpatient hospital care and provider fees associated with these services
- Non-emergency inpatient and outpatient surgical procedures, wherever performed, and provider fees associated with these services
- All non-emergency psychological/psychiatric testing, treatment, and services
- All outpatient psychological/psychiatric testing, treatment, and services
- Inpatient and outpatient care for soft tissue injuries and disc injuries of the neck, back, and related structures, when furnished for any diagnoses other than those included in the Care Paths
- Acupuncture
- All testing and treatment for TMJ disorder or any facial pain syndrome
- Extended care and rehabilitation facilities
- All home health care
- Infusion Therapy
- Bone scans
- Range of Motion Muscle Testing
- Vax-D
- Prescriptions costing more than $50
- Non-emergency dental restoration
- Durable medical goods, including orthotics and prosthetics, that collectively exceed $50 or rental over 30 calendar days
- Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost, or monthly rental cost, in excess of $100, or used for a rental period in excess of 30 calendar days, including but not limited to:
  a. Vehicles
  b. Modifications to vehicles
  c. Durable goods
  d. Furnishings
  e. Improvements, modifications, or alterations to real or personal property
  f. Fixtures
  g. Spa/gym memberships
  h. Recreational activities and trips
  i. Leisure activities and trips
• Physical, occupational, speech, cognitive, or other restorative therapy or body part manipulation (including manipulation under anesthesia), including massage therapy, except as provided for identified injuries in accordance with decision point review
• All pain management services and treatment, including but not limited to:
  a. Acupuncture
  b. Nerve blocks
  c. Manipulation under anesthesia
  d. Anesthesia when administered in conjunction with invasive techniques
  e. Epidural steroid injections
  f. Radio frequency/rhyzotomy
  g. Narcotics, when prescribed for more than three months
  h. Biofeedback
  i. Implantation of spinal stimulators or spinal pumps
  j. Trigger point injections
except as provided for identified injuries in accordance with decision point review

**Voluntary precertification**

**Insured persons** and their health care providers are strongly encouraged to participate in a voluntary precertification process by providing a comprehensive treatment plan for both identified injuries and other injuries. An approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification to us at decision points and for Treatment, Diagnostic Testing or DME requiring precertification is not required.

**NJPIP-1099**

Treatment administered in emergency care, and/or within ten calendar days of the accident, is not subject to decision point review or precertification requirements. This provision shall not be construed so as to require reimbursement for tests and treatment that are not medically necessary, N.J.A.C. 11:3-4.7(b).

If your provider fails to request decision point review/precertification in accordance with this plan where required, or fails to provide clinical findings that support the treatment, testing, or durable medical equipment requested, a co-payment penalty of 50% will apply. For benefits to be reimbursed in full, treatment, testing, and durable medical equipment must be medically necessary.

**Complete requests**

Your health care provider must submit all requests on the Attending Provider Treatment Plan (APTP) form. A copy of the APTP form is available at http://www.nj.gov/dobi/aicrapg.htm or by contacting us at 1-855-243-1331.

Complete requests for decision point review and precertification must be submitted on an APTP form and must include the insured person’s full name and
birth date, the policy number, the claim number, and the date of the **accident**, and must be signed by the provider. Complete requests also must include dates of prior treatment, legible office notes, diagnoses, diagnostic tests performed including the test findings, recommended tests, pre-existing conditions, and any additional information required to review the treatment request. When an incomplete request is received, we will inform your provider that additional medical documentation is required. An administrative denial for failure to provide medical documentation will be issued and will remain in effect until all requested information needed to determine medical necessity regarding the requested treatment is received. Within three business days following receipt of all appropriate documentation, we will provide our determination. Pursuant to N.J.A.C. 11:3-4.4(e) and the policy of insurance, failure to comply with decision point review or precertification requirements will result in a 50% penalty co-payment for any subject treatment or testing that is determined to be medically necessary and causally related to the **accident**. This penalty co-payment will apply to care furnished between the time notification of treatment is required and the time we have had an opportunity to respond after receipt of the requested additional medical documentation.

**How to submit decision point/precertification requests:**

**Decision point/precertification** requests must be faxed to us at:

1-866-841-8312

We shall provide 24-hour, 7-day/week telephone service. Regular business hours are Monday through Friday 8:00 AM - 5:00 PM. All requests for pre-authorization on weekends and holidays will be handled on the next business day. Submitting requests for pre-authorization before or after regular business hours and/or failure to submit the required documentation could result in a delay in receiving a final determination of your request.

**Our** review of decision point/precertification requests and/or extended treatment notifications will be completed within three business days following the day of receipt of the necessary information. Authorized testing, treatment and/or durable medical equipment (DME) is approved only for the range of dates noted in the determination letter(s).

If the injured party’s treating provider fails to follow the procedures listed below, all medically necessary 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-pay of 50%, even if the services are determined to be medically necessary. In order to avoid this penalty, the injured party’s treating provider must follow the appropriate procedure below:

- When medically necessary care or DME is not completed within 14 calendar days from the date in which the authorization period expires, the injured party’s treating provider must request an extension, in writing, to us and the extension request must include the supporting reason for the extension. The request for extension can be faxed to 1-866-841-8312.
• When medically necessary care or DME is completed 30 or more calendar days from the date in which the authorization period expires, the injured party’s treating provider must resubmit a request to us. The request must be submitted in writing and must include a complete APTP form which must contain, but is not limited to, the injured party’s full name, birth date, policy number, claim number, the date of the accident, diagnoses codes and all requested CPT codes listed that are intended to be used and frequency and duration of services for each code. The complete APTP form must be accompanied with appropriate and current progress notes, and results of diagnostic tests or studies relative to the requested services. The resubmitted request can be faxed to 1-866-841-8312.

We shall respond to providers by phone as well as confirm in writing as to whether or not the medical documentation supplied by the treating provider is sufficient. If we fail to notify the insured person or provider within three business days, the insured person may continue with the test or treatment until a final determination is communicated to the insured person or the provider. In addition, if we are unable to make an informed determination based solely on the medical documentation, we may request that the insured person attend an Independent Medical Examination. If an Independent Medical Examination is requested, the scheduling of the appointment date for the physical examination will be completed within seven calendar days from the date that we notified the requesting party that an Independent Medical Examination will be scheduled unless the injured person agrees with us to extend the time period. The physical examination itself will be scheduled to occur within 35 calendar days from receipt of the notice.

The Independent Medical Examination will be conducted by a health care provider within the same specialty as the insured person’s treating health care provider and will be conducted in a location reasonably convenient to the insured person. Results of the Independent Medical Examination and the determination regarding the precertification request will be submitted to the insured person in writing and by telephone within 3 business days after the examination. Please note that medically necessary treatment may proceed while the Independent Medical Examination is being scheduled and until the results are available. If the examining provider prepares a written report concerning the examination, the injured person, or his or her designee, shall be entitled to a copy of the report upon request.

In accordance with the AICRA Regulations, at our request the insured person must provide all medical records and diagnostic studies/tests available before or at the time of the scheduled examination. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the IME. Failure to attend a scheduled examination without first furnishing notice at least 3 business days prior to the examination date, of the need to cancel and reschedule, will be considered an unexcused failure to attend. Rescheduled exams will be scheduled to occur within 30 calendar days of the originally scheduled examination date. Failure to
attend, with or without prior notice, any rescheduled examination will be considered an unexcused failure to attend. If the injured person has two or more unexcused failures to attend a scheduled exam, or three failures in total to attend a scheduled exam, notification will be immediately sent to the injured person or to his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the injured person on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

Unless otherwise indicated, all determinations regarding decision point review and precertifications will be provided by phone and in writing within 3 business days following the day of receipt of the request. If a determination is not rendered within 3 business days following the day of receipt of the request, the treatment or testing may proceed until the insured person and/or the provider have been notified that reimbursement for the treatment or testing is not authorized.

Any denial of treatment or testing based on medical necessity shall be made by a physician or dentist. Medical authorizations are not a GUARANTEE of payment. All claims are subject to regulatory eligibility and coverage investigations, benefit reductions, and/or coverage denials as required and/or permitted by the State of New Jersey.

Voluntary utilization program (waiver of policy co-payment)
As outlined in N.J.A.C. 11:3-4.8, there is a co-payment applicable to certain non-emergency care and services received from non-network providers. Currently, there is a 30% co-payment applicable to diagnostic imaging (MRI and CAT Scan), electrodiagnostic testing listed in N.J.A.C. 11:3-4.5(b)1-3 (except when performed by the treating provider in conjunction with a needle EMG), and durable medical goods greater than $50 cost or rental over 30 calendar days. The co-payment for prescription drugs is $10.

We have a provider network that is available to insured persons. As outlined in N.J.A.C. 11:3-4.8, this network is an approved network as part of a workers’ compensation managed care organization pursuant to N.J.A.C. 11:6. The benefits of the network include ease of access, credentialed and quality providers, and the fact that co-payment is waived when accessing a network provider.

Information regarding the provider network is available at http://www.procura-inc.com or by calling Procura Management Inc. at 1-800-275-9485. This provider network includes Procura Management Inc. providers as well as the Magnacare Network.

In addition, we make available a Preferred Provider Organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. The use of a provider from this PPO is strictly voluntary and is provided as a service to insured persons. A
co-payment penalty will not be applied if you choose to select a provider outside this preferred provider network. Our preferred providers have facilities located throughout the state. Information regarding the PPO network is available to you at www.procura-inc.com or by calling Procura Management Inc. at 1-800-275-9485. This PPO Network includes Procura Management Inc. providers as well as the Magnacare Network.

**Penalty**

As outlined in N.J.A.C. 11:3-4.4(e), failure to request decision point review or precertification as required in this Decision Point Review/Precertification plan will result in a 50% co-payment penalty. This co-payment penalty will be in addition to any co-payment set forth elsewhere in Part II of the policy. Co-payments and deductibles will first be applied to the eligible charges and then co-payment penalties will be applied for failure to precertify.

**Application of co-payments and deductibles**

In accordance with N.J.A.C. 11:3-4.4(h), co-payments and deductibles will be applied in the following order:

a. If applicable, co-payment penalty described in N.J.A.C. 11:3-4.4 (e) and (g);

b. Insured deductible as described in N.J.A.C. 11:3-4.4 (a) and (b);

c. Insured co-payment as described in N.J.A.C. 11:3-4.4 (a).

**Assignment of benefits**

Benefits under this policy part are not assignable except to a health care provider for medical expenses representing covered services and/or supplies furnished by the health care provider to an insured person.

In order for any assignment of benefits to be valid, the health care provider must agree, in writing as part of the assignment, to comply fully with our Decision Point Review Plan, all precertification requirements, and all the terms and conditions of the policy. An assignment that does not explicitly contain such an agreement is invalid.

The health care provider must also agree, in writing as part of the assignment, to hold harmless the insured person, us, and our vendor for any reduction in benefits caused by the health care provider’s failure to fully comply with the terms of our Decision Point Review Plan, all precertification requirements, or the terms and conditions of the policy.

Any and all assignments of benefits by an insured person to a health care provider shall become void and unenforceable under the following conditions:

1. coverage is not afforded under the policy;

2. a health care provider of services and/or supplies does not submit to an Examination Under Oath when we request same;

3. a health care provider of services and/or supplies does not comply with all requests for medical records or test results;
4. a health care provider does not comply with all the requirements, duties and conditions of the policy, including but not limited to all duties of cooperation listed in the “YOUR DUTIES” part of the policy; or
5. a health care provider does not comply with the “Dispute Resolution” provisions in Part II of the policy and in our approved Decision Point Review Plan, including utilization of the Internal Appeal Process.

APPEALS PROCESS

Pre-Service Appeals

If you or an insured person disagree with our determination with respect to a decision point review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment, a written request for appeal must be submitted on the PIP Pre-Service Appeal form by the physician making the initial determination or in his/her absence, another designated physician, through our internal Appeals Process within thirty (30) days of receipt of a written denial or modification. A submission based on additional medical information that is supplied more than thirty (30) days after the initial request will be considered a new request for decision point review or precertification and not an appeal. Submission of information identical to the initial material submitted in support of the request shall not be accepted as a request for appeal. Provided that additional necessary medical information has been submitted, a response to the appeal request shall be made within fourteen (14) days. If it is determined that peer review or an Independent Medical Examination is appropriate, this information will be communicated within ten (10) business days. All requests for pre-service appeals must include, as the cover page, a fully completed PIP Pre-Service Appeal form, which is available at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm#protocol. Request for pre-service appeals under this paragraph must be submitted to us on a completed Pre-Service Appeal Form at njpreserviceappeal@progressive.com. We will neither accept nor respond to pre-service appeals that are sent to any other physical address, fax number, or email address. Only requests for pre-service appeals under this paragraph will be accepted at this email address. Do not submit any other type of correspondence or request to this email address.

Post-Service Appeals

As a condition precedent to filing an arbitration or litigation, a provider who has accepted an assignment, or any insured person, must submit a PIP Post-Service Appeal form to appeal any and all disputes subsequent to the performance or issuance of services, including, but not limited to, any claims for unpaid medical bills for medical 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. In order to be considered valid, a
post-service appeal under this section must be submitted within one-hundred-and-eighty (180) days of service of the adverse decision and at least forty-five (45) days prior to initiating arbitration or litigation. A response to the post-service appeal request shall be made not later than thirty (30) days after receipt of the appeal and all supporting documentation. In addition, all requests for post-service appeal must include, as the cover page, a fully completed PIP Post-Service Appeal form, which is available at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm#protocol. The PIP Post-Service Appeal form must be faxed to us at 877-213-7258. We will neither accept nor respond to post-service appeals that are sent to any other physical address, fax number, or email address. Only requests for post-service appeals under this paragraph will be accepted at this fax number. Do not submit any other type of correspondence or request to this fax number.

In accordance with and subject to the requirements of N.J.A.C. 11:3-4.7B(b), we will require only one appeal for each issue appealed.

If the insured person or a healthcare provider retains counsel to represent them during the Appeals Process, they do so strictly at their own expense. We will not reimburse for counsel fees or any other costs, regardless of the outcome of the appeal.

**Health care providers not holding a valid assignment of benefits**

A health care provider not holding a valid assignment of benefits shall have no right to present any claim or bring any action directly against us for benefits under the policy, regardless of forum. Accordingly, such health care provider may not request or engage in Alternate Dispute Resolution as provided for in NJSA 39:6A-5.1. This paragraph does not preclude a health care provider that is not holding a valid assignment of benefits from participating in the request for internal appeal/reconsideration process set forth in the preceding section.