

**IMPORTANT INFORMATION ABOUT OUR
DECISION POINT REVIEW / PRECERTIFICATION PLAN**

NJ 00 11 03 17

We have contracted with a decision point review / precertification organization to monitor medical treatment for injuries sustained in automobile accidents. The following material summarizes the steps that must be taken if you are to receive maximum reimbursement for the cost of treating your injuries. No coverage is provided by this summary. This summary cannot be construed to replace any provision of your policy. You should read your policy and review your Declarations page for complete information on the coverages that are provided. If there is any conflict between the policy and this summary, **THE PROVISIONS OF THE POLICY SHALL PREVAIL.**

If you are involved in an automobile accident:

- Report the accident to your local Amica branch office as soon as possible. **We may impose a co-payment penalty if the accident is not reported to us within thirty (30) days.** Please see the section below under **Penalty for Late Notification** for additional information.

When you report an accident, we will:

- Ask for details about the accident and the damages and injuries sustained;
- Explain the coverage provided by your policy;
- Explain the procedures required for the review and monitoring of medical treatment;
- Explain the consequences for failing to comply with the review procedures; and
- Ask for the name of the doctor treating you for any injuries.

We will then notify our decision point review / precertification organization that you have been injured. Our Decision Point Review / Precertification Plan organization is:

Prizm LLC
10 East Stow Road, Suite 100
Marlton, NJ 08053
Toll Free 1-856-596-5600
Fax No. 1-856-596-6300
www.prizmlc.com

Please note: Prior review of medical treatment or tests is not needed for emergency care following an accident, or for treatment received within ten (10) days of the accident.

When notified of the accident, Prizm will:

- Contact your doctor for details about your injuries and an initial diagnosis;
- Ask your doctor about the medical treatment planned for you;
- Explain the steps your doctor must take to receive the maximum payment for services rendered allowed under the policy and New Jersey insurance regulations;
- Explain how your doctor can appeal if Prizm determines that certain treatment is not medically necessary for your injuries;
- Request that your doctor send Prizm a written treatment plan for your injuries;
- A written authorization, denial or request for more information is provided by fax and then followed by mail within three (3) business days.

Penalty for Late Notification

If the accident is not reported to us within thirty (30) days, we may reduce any payment you receive for covered injuries as follows:

- A 25% reduction if we are notified thirty (30) or more days after the accident; or
- A 50% reduction if we are notified sixty (60) or more days after the accident.

IMPORTANT INFORMATION ABOUT OUR DECISION POINT REVIEW / PRECERTIFICATION PLAN

NJ 00 11 03 17

Any reduction will affect reimbursement for covered medical expenses you incur beginning thirty (30) days after the accident and until we are notified of the accident. The reduction will be applied:

- After any medical expense benefits deductible or co-payments; and
- After any other co-payments imposed under our Decision Point Review / Precertification Plan.

Diagnostic tests and other medical services

New Jersey insurance regulations establish standard courses of treatment (Care Paths) for certain neck, back and soft tissue injuries that may result from an auto accident. These injuries are known as "identified injuries". Exhibit A contains a list of the identified injuries. Treatment proposed for identified injuries must conform to the Care Paths, unless special circumstances indicate that other treatment is medically necessary. A copy of the Care Paths can be obtained from Amica or Prizm.

For any type of injury, New Jersey Insurance regulations require that the use of certain diagnostic tests be reviewed and monitored. These diagnostic tests are listed in Exhibit B. In addition, if you do not have an identified injury, we require that a number of medical services be reviewed and monitored. These services are also listed in Exhibit B.

New Jersey insurance regulations and your policy provide that no reimbursement will be afforded under your personal injury protection coverage for the following diagnostic tests:

- Iridology;
- Mandibular tracking and simulation;
- Reflexology;
- Spinal diagnostic ultrasound;
- Surface electromyography (surface EMG);
- Surrogate arm mentoring;
- Any other diagnostic test that is determined by New Jersey Law or regulation to be ineligible for Personal Injury Protection Coverage.

New Jersey insurance regulations and your policy provide that no reimbursement will be made under your personal injury protection coverage for the following treatments:

- Kinesio Tape
- X-ray Digitization
- Any other treatment/test that is determined by New Jersey Law or regulation to be ineligible for Personal Injury Protection Reimbursement.

Decision Point Review / Precertification Procedure

Your doctor will be asked to submit a comprehensive treatment plan for your injuries. Prizm will review the plan. The plan will be approved if Prizm agrees that the treatment proposed is medically necessary. Your doctor will be notified of the outcome of the review three (3) business days after Prizm's receipt of all necessary information. Treatment may continue while Prizm reviews the treatment plan. However, you and your doctor should be aware that **your policy affords coverage only if treatment is determined to be medically necessary.**

Providers who submit Decision Point Review/Precertification requests are those providers who, in part, physically and personally perform evaluations of the injured persons condition, state the specific treatment and set treatment goals.

**IMPORTANT INFORMATION ABOUT OUR
DECISION POINT REVIEW / PRECERTIFICATION PLAN**

NJ 00 11 03 17

Decision Point Review/Precertification requests will not be accepted from the following providers:

- Hospitals
- Radiologic Facilities
- Durable Medical Equipment Companies
- Ambulatory Surgery Centers
- Registered bio-analytical laboratories;
- Licensed health maintenance organizations;
- Transportation Companies
- Pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request Prizm will respond to them no later than three (3) business days after the receipt of the request informing that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

If your doctor submits a treatment plan and the plan is approved:

- Medical expenses consistent with the approved plan will be paid without requiring further review for each step of your treatment;
- The coverage afforded will be subject to the medical services fee schedules contained in the New Jersey insurance law or regulations; and
- The coverage afforded will be subject to the limits, deductibles and co-payment requirements of your policy.

If no treatment plan is submitted, and you have an identified injury (see Exhibit A):

- You and your doctor must be certain that your treatment conforms to the Care Paths contained in the New Jersey insurance regulations;
- Prizm must receive a request for any diagnostic test listed in Exhibit B, you will be notified three (3) business days after Prizm's decision.
- Failure to request or receive an authorization from Prizm at the Decision Points within the Care Paths or prior to the use of medical services outside of the Care Paths may result in reduced coverage for medically necessary treatment.

If no treatment plan is submitted, and you do not have an identified injury:

- Prizm must receive a request for any diagnostic test and medical service listed in Exhibit B, you will be notified three (3) business days after Prizm's decision.
- Failure to request or receive an authorization from Prizm prior to the use of any of the tests or services listed in Exhibit B may result in reduced coverage for medically necessary treatment.

Consequences of Failure To Notify Prizm as Required

Unless the use of medical products and services is approved as part of a comprehensive treatment plan, Prizm must receive a request:

- Any time a diagnostic test listed in Exhibit B is to be used; or
- If you have an identified injury (see Exhibit A) and are at a Decision Point within the Care Paths or treatment outside of the New Jersey regulations' Care Paths is planned; or
- If you do not have an identified injury but use of any of the services or products listed in Exhibit B is planned.

You will be notified of Prizm's decision within three (3) business days. If Prizm fails to respond within three (3) business days after receipt, the treatment, testing or durable medical equipment may proceed until the Prizm notifies the provider that reimbursement for the treatment or testing is not authorized.

**IMPORTANT INFORMATION ABOUT OUR
DECISION POINT REVIEW / PRECERTIFICATION PLAN**

NJ 00 11 03 17

You will be responsible for a co-payment of 50% of the expenses for medical services or products if you do not obtain authorization from Prizm as required.

This means you must first pay your deductible plus any applicable co-payment, and will then be responsible for 50% of any remaining medical expenses for these medical services.

No coverage will be afforded for treatment or services that are not medically necessary.

Internal Appeal Process

If Prizm's Physician Advisor has determined that treatment is not medically necessary, coverage for the treatment will be denied. This written decision will be faxed followed by mail. Prizm's Physician Advisor will be available to discuss the decision with your doctor. Prizm will grant a request for reconsideration of its decision when additional information can be provided to Prizm for a second review. If reconsideration cannot resolve the difference of opinion, the matter may be appealed.

● **Pre-service Appeals**

Your doctor must request an internal appeal, regarding a decision related to a treatment request prior to the performance or issuance of the requested service. This request must be submitted within thirty (30) days of Prizm's decision denying coverage. This appeal must contain a properly completed Pre-Service Appeal Form in accordance with NJAC 11:3-4.7(d), the original Attending Providence Treatment Plan (AFTP) being appealed, the AFTP Decision/Response document being appealed, an appeal rationale narrative and the appeal physician's signature and the reason(s) for reconsideration along with any additional supporting documentation. If the required information is not submitted at the time the pre-service appeal is received, the appeal will be denied. The provider will be notified of the inefficiencies contained in the appeal submission and will be given the opportunity to resubmit correctly.

If it is determined that an Independent Medical Examination is necessary, the appointment shall be scheduled within seven (7) days of the appeal request unless the injured person agrees to extend the time period.

Prizm's written response to the appeal will be communicated to the provider within fourteen (14) days after the receipt of the appeal request.

● **Post-service Appeals**

If the appeal is for any issue, other than treatment denials or modifications done by a Physician Advisor Review or an IME, subsequent to the performance or issuance of the services, a treating provider must request reconsideration through Prizm. The request must be made in writing within ninety (90) days of receipt of the explanation of benefits and at least forty-five (45) days prior to initiating alternate dispute resolution pursuant to N.J.A.C 11:3-5. The request must include a properly completed Post-Service Appeal Form in accordance with NJAC 11:3-4/7(d), the original Bill, the Explanation of Benefit/Payment, the signature of the treating provider and reason(s) for reconsideration along with any additional supporting documentation. If the required information is not submitted at the time the post-service appeal is received, the appeal will be denied. The provider will be notified of the inefficiencies contained in the appeal submission and will be given the opportunity to resubmit correctly.

Prizm's written response to the appeal will be communicated to the provider within thirty (30) days after the receipt of the appeal request.

All appeals should be submitted to Prizm via fax at (856) 596-6300, electronically at Documents@prizmlc.com or mailed to PO Box 986 Marlton, NJ 08053.

Each issue requires one internal appeal submission prior to making a request for alternate dispute resolution. If the treating provider is not satisfied with the results of Prizm's Internal Appeals Process, the treating provider may Dispute Resolution as per N.J.A.C 11:3-5. **Failure to comply with the Decision Point Review/Precertification Plan or the Requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy.** If an emergency arises, your doctor can request an expedited appeal for medical services that should not be delayed.

If the treating provider accepts assignment for payment of benefits they are required to hold harmless the insured and the insurer for any reduction of benefits caused by the treating provider's failure to comply with the terms of the Decision Point Review/Pre-Certification Plan. The appeals process above must be followed by any treating provider who has accepted an assignment of benefits. If the treating provider has a valid assignment of benefits, an appeal must be submitted to Prizm forty-five (45) days prior to the initiation of any arbitration or litigation.

**IMPORTANT INFORMATION ABOUT OUR
DECISION POINT REVIEW / PRECERTIFICATION PLAN**

NJ 00 11 03 17

What else?

If they are determined to be medically necessary, the following medical products and services will be available through Prizm's approved Voluntary Network Providers:

- Durable medical equipment (such as wheel chairs and hospital beds) in excess of \$100.00;
- Diagnostic imaging tests such as MRIs;
- Electronic diagnostic tests including but not limited to EEGs, NCVs and EMGs;
- Prescription drugs; and
- Computer Assisted Tomograms (CAT, CT scans).

If you purchase these items through Prizm's network of providers, expenses incurred will be fully covered subject to policy provisions if:

- You have an identified injury (see Exhibit A) and use of the test or service conforms with the New Jersey insurance regulations' Care Path for your injury; and
- You have received authorization from Prizm, as required, that a diagnostic test listed on Exhibit B may be planned; or
- You do not have an identified injury, and Prizm has authorized use of any of the services and products listed in Exhibit B.

With the exception of prescription drugs, you will be responsible for a co-payment of 30% if the above circumstances are met but you do not purchase the available items through Prizm's network. This means you must first pay your deductible plus any applicable co-payment amounts, and will then be responsible for 30% of the remaining costs for the products and services.

A \$10.00 co-payment will apply to the purchase of prescription drugs if they are not obtained through Prizm's network. The \$10.00 co-payment will apply each time a prescription is filled or re-filled.

You will be responsible for a co-payment of 50% of the expenses for the items available through Prizm's network if you do not receive authorization from Prizm as required. This means you must first pay your deductible plus any applicable co-payment amounts, and will then be responsible for 50% of the remaining costs for the products and services. Notification is not required prior to the purchase of prescription drugs.

Physical Exams Required By Your Policy

If we are unable to determine if further treatment, diagnostic testing or durable medical equipment is necessary, you may be required to submit to a physical or mental Independent Medical Examination (IME).

The IME will be scheduled within seven (7) calendar days of the date of the request, with a doctor in the same discipline as the treating provider and at a location reasonably convenient to you. You are required to provide medical records and other pertinent information to the provider conducting the exam. The records shall be provided at the time of the examination or before. We will notify your treating provider no later than three (3) business days after the examination if we will reimburse for any further treatment, diagnostic tests or durable medical equipment. A copy of the examining report is available to you or your treating provider upon request.

Expenses will not be reimbursable if there are unexcused failures to appear at two (2) or more scheduled appointments. The following constitutes an unexcused failure:

Failure to attend a scheduled IME without proper notice to Prizm

Failure to notify Prizm at least two (2) days prior to the IME date

Any reschedule of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from Amica Insurance.

Failure to provide requested medical records, including radiology films, at the time of the IME

If the injured party being examined does not speak English, and they fail to request or provide an English speaking Interpreter for the exam.

The treating provider will be notified by fax or mail if the injured party has a second unexcused failure to attend the IME. This notification will state no further reimbursement can be made.

**IMPORTANT INFORMATION ABOUT OUR
DECISION POINT REVIEW / PRECERTIFICATION PLAN**

NJ 00 11 03 17

Payments and Reimbursement

All eligible medically necessary services will be reimbursed in accordance with the most current New Jersey PIP Regulations and Fee Schedule relating to the date of service.

When provider fees aren't noted in a fee schedule, the most current version of FAIR Health Data Base will be used, consistent with the date of service, 75th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee.

For Pharmacy bills which aren't noted in a fee schedule, the most current version of the Goldstandard will be used with the geozip noted on the provider's address noted on this EOB.

If the provider participates in an applicable PPO network, services may be reimbursed in accordance with the amount permitted under the PPO agreement.

There is no obligation to reimburse for specific CPT/HCPC codes if they were approved (certified) in a Decision Point Review/Precertification request as it relates to applying payment methodology in the NJ PIP regulations, including but not limited to the NCCI edits. If the NCCI edits prohibit reimbursement for the codes that were billed such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of Amica Insurance Company's obligation to only reimburse for medically necessary treatment.

To obtain the entire current NCCI edits from the following web site: www.cms.gov/NationalCorrectCodInitEd/

If you have any questions about the above information, please call us.

**Amica Mutual Insurance Company
Amica Property and Casualty Insurance Company**

Northern New Jersey Office
One Maynard Drive
Suite 1104
Park Ridge, NJ 07656-1878
Toll Free 1-800-762-6422

Southern New Jersey Office
1000 Bishops Gate Boulevard
Suite 200
Mount Laurel, NJ 08054-4634
Toll Free: 1-888-592-6422

**IMPORTANT INFORMATION ABOUT OUR
DECISION POINT REVIEW / PRECERTIFICATION PLAN**

NJ 00 11 03 17

**EXHIBIT A
Identified Injuries**

The following neck, back and soft tissue injuries are known as "identified injuries" under New Jersey insurance regulations. The regulations contain standard courses of medical treatment known as Care Paths for these injuries. Treatment for identified injuries must conform to the Care Paths unless other treatment is determined to be medically necessary.

<u>ICD-9 Code</u>	<u>Description</u>
722.0	Displacement of cervical intervertebral disc without myelopathy
722.1	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.10	Displacement of lumbar intervertebral disc without myelopathy
722.11.1	Displacement of thoracic intervertebral disc without myelopathy
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.70	Intervertebral disc disorder with myelopathy, unspecified region
722.71	Intervertebral disc disorder with myelopathy, cervical region
722.72	Intervertebral disc disorder with myelopathy, thoracic region
722.73	Intervertebral disc disorder with myelopathy, lumbar region
728.0	Disorders of muscle, ligaments and fascia
728.85	Spasm of muscle
739.0	Non-allopathic lesions - not elsewhere classified
739.1.1.1	Somatic dysfunction of cervical region
739.1.1.2	Somatic dysfunction of thoracic region
739.3	Somatic dysfunction of lumbar region
739.4	Somatic dysfunction of sacral region
739.8	Somatic dysfunction of rib cage
846.0	Sprains and strains of sacroiliac region
846.1	Sprains and strains of lumbosacral (joint)(ligament)
846.2	Sprains and strains of sacrospinatus (ligament)
846.3	Sprains and strains of sacrotuberous region
846.8	Sprains and strains of other specified sites of sacroiliac region
846.9	Sprains and strains of unspecified site of sacroiliac region
847.0	Sprains and strains of neck
847.1	Sprains and strains, thoracic
847.2	Sprains and strains, lumbar
847.3	Sprains and strains, sacrum
847.4	Sprains and strains, coccyx
847.9	Sprains and strains of back, unspecified site
922.3	Contusion of back
922.31	Contusion of back, excludes interscapular region
922.33	Contusion of back, interscapular region
953.0	Injury to cervical root
953.2	Injury to lumbar root
953.3	Injury to sacral root

**IMPORTANT INFORMATION ABOUT OUR
DECISION POINT REVIEW / PRECERTIFICATION PLAN**

NJ 00 11 03 17

**EXHIBIT B
DIAGNOSTIC TESTS**

Beginning on the eleventh day following an automobile accident, Prizm must receive at least three (3) business days notice if the following diagnostic tests are planned:

- | | |
|--|--|
| 1. Brain audio evoked potentials (BAEP); | 9. Needle electromyography (EMG); |
| 2. Brain evoked potentials (BEP); | 10. Nerve conduction velocity (NCV); |
| 3. Brain mapping; | 11. Somasensory evoked potential (SSEP); |
| 4. Computer assisted tomograms (CT, CAT scan); | 12. Sonogram/Ultrasound; |
| 5. Dynatron/cybex station/cybex studies; | 13. Thermogram/Thermography; |
| 6. Electroencephalogram (EEG); | 14. Videofluoroscopy; |
| 7. H-reflex studies; | 15. Visual evoked potential (VEP). |
| 8. Magnetic resonance imaging (MRI); | |

OTHER MEDICAL SERVICES AND PRODUCTS

Beginning on the eleventh day following an automobile accident, Prizm must receive at least three (3) business days notice if use of the following medical services and products is planned:

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Extended Care Rehabilitation Facilities
4. All Outpatient care for soft tissue/disc injuries of the person's neck, back and related structures not included within diagnoses covered by the Care Paths
5. All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except as provided for Identified Injuries in accordance with Decision Point Review
6. All Outpatient psychological/psychiatric testing/testing or other services
7. All pain management services, except as provided for identified injuries in accordance with decision point review
8. Home Health Care
9. Acupuncture
10. Durable Medical Equipment (including orthotics and prosthetics) with a costly or monthly rental in excess of \$100.00
11. Non-Emergency medical transport with a round trip transportation in excess of \$100
12. Non-Emergency Dental Restorations
13. Temporomandibular disorder; any oral facial syndrome
14. Infusion Therapy
15. Current Perception Testing
16. Computerized Muscle Testing
17. Nutritional Supplements
18. All treatment and testing related to balance disorders
19. Bone Scans
20. Podiatry
21. Urine drug testing for prescription management or drug abuse identification
22. Prescription Drugs costing more than \$100.00
23. Any procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPC code