



NEW JERSEY 21-DAY NOTICE GUIDELINES AND PRECERTIFICATION GUIDELINES

According to this policy, any benefits paid under New Jersey No Fault coverage will be subject to a deductible (determined by the named insured on the policy at the time of issuance) and all payments will be reduced by a 20% Copayment up to the first \$5000.00 in medical expenses. All medical benefits in excess of \$5000.00 deemed medically necessary and related to this patients injuries, sustained as a result of this accident, will then paid be paid at 100% of the New Jersey Fee Schedule Guidelines and/or reasonable and customary charges. Any and all reductions in payments that are taken as a result of the policy deductible and/or copayment will be the financial responsibility of the patient. Any and all payments are subject to your strict adherence to the the following requirements and conditions.

Penalty/Co-Payments

If requests for decision point reviews are not submitted as required or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty (50) percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment under the Personal Injury Protection coverage.

If requests for precertification are not submitted as required or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty (50) percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment required under the Personal Injury Protection coverage.

FOR THE PURPOSES OF THE PENALTY/CO-PAYMENTS NOTED ABOVE AND ALL DEDUCTIBLES, THE ORDER OF APPLICATION WILL BE CONSISTENTLY APPLIED IN THE FOLLOWING MANNER: CO-PAYMENTS PURSUANT TO N.J.A.C. 11:3-4.4(d) (FAILURE TO REQUEST DECISION POINT REVIEW OR PRE-CERTIFICATION REVIEW), N.J.A.C. 11:3-4.4(e) (FAILURE TO PROVIDE TIMELY INFORMATION ABOUT INJURY AND/OR CLAIM), AND N.J.A.C. 11:3-4.4(f) (FAILURE TO USE AN APPROVED DIAGNOSTIC, DURABLE MEDICAL OR PRESCRIPTION DRUG NETWORK), SHALL BE APPLIED BEFORE THE APPLICATION OF OTHER CO-PAYMENTS OR DEDUCTIBLES, INCLUDING THOSE IDENTIFIED IN N.J.A.C. 11:3-4.4(a) AND (b) (STANDARD AND OPTIONAL DEDUCTIBLE AND CO-PAYMENTS).

CorVel Corporation (Corvel) has been designated by Banker's Standard Insurance Co, to provide Decision Point Review/Pre-certification, medical service review and medical fee schedule calculations of this claim. Pursuant to N.J.A.C. 11:3-4, you are required to notify us of those medically necessary services you intend to perform on the patient, as hereinafter explained. CorVel is the Company's utilization review organization for these purposes. Please note that none of these procedures apply until 10 days have elapsed following the patient's accident and in no event to emergency care.

Care Paths/Decision Point Review

As mentioned above, pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance (NJDOBI) has published standard courses of treatment, Care Paths, for soft tissue injuries of the neck and back, collectively referred to as the “Identified Injuries”. For a list of “Identified Injuries” by ICD9 codes, please see attachment. 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 must provide us information about further treatment you intend to provide. This is called “Decision Point Review” or DPR. In addition, the administration of any test listed on the attached exhibit also requires DPR, regardless of the diagnosis. If you fail to submit requests for DPR, or fail to submit clinically supported findings to support the request, reimbursement of your bills may be subject to a penalty co-payment, even if the services are subsequently found to have been medically necessary. The Care Paths and accompanying rules are available on the Internet at the NJDOBI website at <http://www.nj.gov/dobi/aicrapg.htm> or by calling CorVel at 800-491-8350.

Mandatory Pre-Certification

If your patient does not have an “Identified Injury”, you are required to obtain Pre-certification of all the services listed below. If you fail to pre-certify such services, or fail to submit clinically supported findings to support the request, the reimbursement of your bills may be subject to a penalty co-payment even if the services are subsequently determined to be medically necessary. You are encouraged to maintain communication with CorVel on a regular basis as Pre-certification requirements may change. Pre-certification is mandatory as to any of the following medical services once 10 days have elapsed since the accident:

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Outpatient care for soft tissue/disc injuries of the insured person’s neck, back and related structures not included within the diagnoses covered by Care Paths
- Temporomandibular, any oral facial disorders
- Non-emergency dental restoration
- Carpal tunnel syndrome
- Outpatient psychological/psychiatric test and/or services
- Home health care
- Skilled nursing care
- Infusion therapy
- Durable medical equipment (including orthotics and prosthetics), leased or purchased for more than \$250 (or the rental of which exceeds 30 days)
- Extended care and rehabilitation facilities
- Physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation except that provided for “Identified Injuries” in accordance with Decision Point Review
- All Pain Management services except as provided for in “Identified Injuries” and in accordance with Decision Point Review

Voluntary Pre-Certification

You are also encouraged to participate in a Voluntary Pre-certification process by providing CorVel with a comprehensive treatment plan for “Identified Injuries” and any other injuries suffered by the patient. CorVel will utilize the Care Paths and nationally accepted criteria to develop a mutually acceptable course of treatment with you, including itemized services (such as diagnostic imaging) and a defined treatment period. If you participate in this Voluntary Pre-certification process, your bills will be paid without any utilization audit (provided that they are consistent with the pre-certified treatment plan). In addition, having an approved treatment plan means that, so long as treatment is consistent with the plan, additional notification to CorVel will not be necessary at “Decision Points”. And, as you continue to participate in the Voluntary Pre-certification process as to subsequent services, payment for any pre-certified services will be made without utilization audit.

How to Submit Decision Point Review/Pre-Certification Requests

In order for CorVel to complete our review, we require that you provide us with any medical history that is available. We also require the diagnosis, prognosis, all x-ray and other test results that may have been completed as well as documentation of all treatment provided to date. Please also indicate any additional tests or treatment you anticipate providing over the course of the next 30 days.

As a rule, you must submit the NJDOBI mandated treatment request form, as to any treatment involving a Care Path, DPR, Mandatory Pre-certification or Voluntary Pre-certification. Please return this completed form, along with a copy of your most recent/appropriate progress notes, all clinically supported findings and the results of diagnostic tests relative to the requested services to us at the following address: **CorVel Corporation, 51 Haddonfield Road, Suite 200, Cherry Hill, NJ 08002, Attn: ACE Private Risk Services Case Management Department. The phone number is 800-491-8350.**

Our review will be completed within three (3) business days of our receipt of the necessary information and notice of our decision will be communicated to your office by telephone and confirmed in writing. If we fail to notify you within 3 business days, you may continue your test or course of treatment until such time as our final determination is communicated to you. Similarly, if an independent physical or mental examination should be required, you may continue your tests or course of treatment until the results of the examination become available. If prepared, a copy of the examining provider’s report will be available upon request.

CorVel personnel will follow up with you towards the end of an already authorized treatment plan to check on your patient’s progress. If additional treatment or any modification of your patient’s pre-certified treatment plan is recommended (inclusive of consultations), it is required that you complete a treatment plan form prior to initiating care.

Possible Outcomes

The following are the possible outcomes of our review:

- The requested service is certified.
- If we receive information that, in our view, is insufficient to support the requested procedure, we will issue an administrative non-certification and will continue to deny the requested procedure until such time as we receive clinical documentation sufficient to evaluate the request.
- In the event that we feel a change in the requested procedure is advisable (whether in frequency, duration, intensity or place of service or treatment), we will notify your office by phone and confirm in writing. A CorVel Medical Director will be available to discuss the case with you.
- In the event that we are unable to certify your request, your office will notified by telephone and confirmed in writing. A CorVel Medical Director will be available to discuss the case with you. We may also request that the patient undergo an Independent Medical Examination (IME). Any such exam will be scheduled within seven (7) business days of our receipt of your Decision Point Review or Pre-certification request (unless the patient agrees to extend the time for such an exam), conducted by a healthcare provider having credentials that are similar to yours and conducted at a location reasonably convenient to the patient/insured.
- Pursuant to N.J.A.C. 11:3-4 and Company policy, failure to follow the Decision Point Review or Pre-certification requirements or failure to submit clinically supported findings to support your request can result in an additional 50% co-payment penalty even for services or tests that are subsequently determined to be medically necessary.

Any decision to deny a request based on medical necessity will be made by a physician or dentist. It is our intention to make this review process quick and simple. As mentioned above, however, in the event we do not respond to any request you submit within 3 business days, you may continue your tests or course of treatment until such time as our determination is sent to you.

Reconsideration Process

If CorVel fails to certify a requested test or service, the clinical rationale for this determination is available to you upon request. You are encouraged to use CorVel's internal review process by contacting us at 800-491-8350 and indicate you are requesting an "internal review". This process will afford you the opportunity to discuss your appeal with a like-specialty Medical Director or request an independent medical examination scheduled by CorVel. A decision regarding your request will be communicated to you within 3 business days. If an IME is scheduled, it will be in accordance with the information provided on the attached Information Sheet.

Assignment of Benefits

Please note that, if you accept an assignment of benefits from a patient, you are required to hold the insured harmless from any reduction in benefits caused by a failure on your part to follow the Decision Point Review/Pre-certification process. All assignments are subject to all requirements,

duties and conditions of the patient's/insured's policy including but not limited to, Pre-certification, Decision Point Reviews, exclusions, deductibles and co-payments.

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Voluntary Utilization Program

Please note that the policy includes a voluntary utilization program for durable medical equipment over \$250 (or if rental of such equipment exceeds 30 days) and diagnostic imaging (Magnetic Resonance Imaging and Computer Assisted Tomography). If an insured uses a network provider for these services or tests, he/she will not be charged an additional 30% co-payment. To obtain additional information about this program, please call 800-491-8350.