

**CLARENDON NATIONAL INSURANCE COMPANY
PERSONAL INJURY PROTECTION**

IMPORTANT NOTICE TO POLICYHOLDERS MEDICAL PROTOCOLS

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 (See Exhibit A)**. 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 Procura Management Inc. information about further treatment the provider intends to pursue. This is called Decision Point Review. Updated amendments effective October 27, 2004 are available for review at <http://www.nj.gov/dobi/aicrapg.htm>. The Clarendon National Insurance Company Decision Point Review Plan is available in hard copy by calling Procura Management at 1-800-275-9485, and is also available at www.procura-inc.com.

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

For treatment of injuries other than an "Identified Injury" (soft tissue injury of the neck or back), you or your providers are required to obtain pre-certification for all of the services listed below. If you or your providers fail to pre-certify such services or fail to provide clinically supported findings

that support the treatment, diagnostic tests or DME requested, payment of bills will be subject to a penalty cop-payment of 50% even if the services are determined to be medically necessary. The following treatments, services, goods and non-medical expenses require pre-certification, unless they are part of a previously approved treatment plan.

- Non-Emergency Inpatient and Outpatient Hospital Care
- All Non-Emergency Psychological/Psychiatric Services
- Extended Care and Rehabilitation Facilities
- All Home Health Care
- Non-Emergency Dental Restoration
- Durable Medical Goods, including orthotics and prosthetics, that collectively exceed \$50.00 rental over 30 days
- Physical, Occupational, Speech, Cognitive, or other restorative therapy of Body part manipulation, including massage therapy, except that provided for Identified Injuries in accordance with Decision Point Review
- All Pain Management services, except as provided for Identified Injuries in accordance with Decision Point Review.

In addition, any of the above treatments may be subject to at least one additional medical opinion, from an Independent Physician, as well as a possible request for an Independent Medical Examination prior to our authorization of services.

PROPER NOTIFICATION:

Your loss (accident) must be promptly reported to the Insurance Company with the appropriate information about the injury and the claim. This requirement includes the production of information fully disclosing all facts about the accident and all parties involved, the nature and cause of the injury, and the diagnosis and the anticipated course of treatment. Untimely and/or insufficient notice shall result in additional penalty co-payments as later described.

Such notice includes the completion of:

- Medical forms by a licensed health care professional
- HIPAA compliant Medical Authorizations
- An Application for PIP benefits
- An Affidavit of No Insurance when required
- A driver's or claimant's written statement which shall include a description of the loss, damage to the vehicle(s) and the estimate of repairs, all vehicles involved, and information regarding injured parties
- Any other documentation of the loss details, such as a police accident or incident report
- Documents requested to confirm eligibility and coverage

VOLUNTARY PRE-CERTIFICATION:

You and your health care provider are strongly encouraged to participate in a Voluntary 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 approved plan, additional notification to Procura Management Inc. at Desician Points for Treatment, Diagnostic Testing or DME requiring pre-certification is not required.

NJPIP-1099:

Treatment obtained in an emergency situation and/or within ten days of the insured event is not subject to decision point review/pre-certification requirements. This provision shall not be construed so as to require reimbursement of 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/pre-certification where required or fails to provide clinical findings that support the treatment, testing or durable medical equipment requested a copayment penalty of 50% will apply even if the services are determined to be medically necessary.

COMPLETED REQUEST:

Complete requests consist of the patient's full name and birth date, the policy holder's name, the policy number, the claim number, the date of the accident, dates of prior treatment, legible office notes, diagnoses, diagnostic tests performed and their findings, recommended tests, pre-existing conditions and any additional information required to review your treatment request.

When an **incomplete** request is received, your health care provider will be informed by Procura Management, Inc. that additional medical documentation is required. A denial for failure to provide medical documentation will be issued and will remain in effect until such time that all requested information needed to determine medical necessity regarding the requested treatment is received. Upon receipt of all appropriate documentation, within three business days, Procura Management, Inc. will provide its determination. Failure to provide requested medical documentation will result in penalty copayments.

HOW TO SUBMIT DECISION POINT/PRE-CERTIFICATION REQUESTS:

Decision Point/Pre-certification request should be submitted to Procura Management Inc. at the following address:

Procura Management Inc.
2435 Boulevard of The Generals, Suite 200, Norristown, PA 19403
1-800-275-9485
Fax: 610-631-7011

Procura Management Inc. shall provide 24 hour, 7-day/week- telephone service. Regular business hours are Monday through Friday 7:30 AM – 5:00 PM. All requests for pre-authorization on weekends and holidays will be handled on the next business day.

Your medical provider must submit all requests on the “Attending Provider Form.” A copy of the “Attending provider Form” is available at <http://www.nj.gov/dobi/aicrapg.htm> or by contacting Procura Management Inc. at 1-800-275-9485, or at www.procura-inc.com. Failure to submit the required documentation could result in a delay in receiving a final determination of your request.

Procura Management Inc.’s review of decision point/pre-certification requests and/or extended treatment notifications will be completed within 3 business days of receipt of the necessary information.

Procura Management Inc. 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 claimant or provider within 3 business days, you may continue with the test or treatment until our final determination is communicated to you or your provider. In addition, Procura Management Inc. or the insurance carrier may request that you attend an Independent Medical Examination. If an Independent Medical Examination is requested, the appointment for the physical examination will be scheduled within 7 calendar days of receipt of the notice, unless the injured person agrees with Procura Management Inc. to extend the time period.

The Independent Medical Examination will be conducted by a health care provider within the same specialty of your treating health care provider and will be conducted in a location reasonably convenient to you. You and your representative will be informed, in writing, of the appointment information. It is your responsibility to provide the Insurance Company with your updated and accurate mailing address. Results of the Independent Medical Examination and the determination regarding your pre-certification request will be submitted to you in writing and to your health care provider in writing and by telephone within 3 business days after the examination. Please note that your 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, you 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. If the injured person has 2 or more unexcused failures to attend the 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’s 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 pre-certifications from Procura Management Inc. will be provided by phone and in writing within 3 business days of receipt of the request. If a determination is not rendered within 3 business days of receipt of the request, the treatment or testing may proceed until you and/or your 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.

VOLUNTARY UTILIZATION PROGRAM (Waiver of Policy Copayment):

Currently, you have a 30% co-payment for 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), durable medical goods greater than \$50.00 cost or rental over 30 days. Your copayment for prescription drugs is \$10.00.

Procura Management Inc. has a provider network that is available to you. As outlined in N.J.A.C. 11:3-4.8, the Procura 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 your copayment is waived when accessing a network provider.

Information regarding our provider network is available to you at www.procura-inc.com or by calling Procura Management Inc. at 1-800-275-9485. Our provider network includes Procura Management Inc. providers as well as the Magnacare Network.

In addition Procura makes available a Preferred Provider Organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. The use of a provider from our PPO is strictly voluntary and is provided as a service to you. A copayment penalty will not be applied if you choose to select a provider outside this preferred provider network. Procura's preferred providers have facilities located throughout the state. Information regarding our PPO network is available to you at www.procura-inc.com or by calling Procura Management Inc. at 1-800-275-9485. Our 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(d), failure to request decision point review or pre-certification as required in our Decision Point Review/Pre-certification plan will result in a 50% copayment penalty. This copayment penalty will be in addition to any copayment stated in the schedule of your policy. Failure to submit clinically supported findings that support your decision point review or pre-certification request will result in a 50% copayment penalty.

Failure to provide timely notice of a loss and supply the required information shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. Any

reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment. The additional co-payment shall be an amount no greater than:

- 25% when received 30 or more days after the accident
- 50% when received 60 or more days after the accident

ASSIGNMENT OF BENEFITS:

We may, at our option, pay any medical expense benefits or essential service benefits to you or your health care provider. These benefits shall not be assignable except to providers of service benefits. Any attempt to assign benefits to a party who is not a provider of service benefits shall be null and void and shall not be honored. If so assigned, all requirements, duties of cooperation following an accident or loss, shall remain in effect. If a valid assignment is made by you and accepted by your provider of the assigned service benefits, your provider shall indemnify and hold harmless you for any deduction or declination in benefits caused by your provider's failure to comply with the terms of this plan.

INTERNAL APPEAL PROCESS:

You or 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.

You or your treating health care provider can simply call Procura Management Inc. within 30 days from the date of an adverse determination of the decision point review and/or the pre-certification. When you or your provider call, the matter of dispute must be explained and have medical rationale to support you or your health care Provider's position. If necessary, Procura Management Inc. may request that appropriate medical documentation be submitted. The treating provider may speak to the medical director in regards to the appeal. A determination of your appeal will be provided within 14 (fourteen) business days. If further documentation is required, a determination will be provided within 14 (fourteen) business days of receipt of documentation.

When an appeal determination does not resolve a difference of opinion, the attending or ordering provider may submit the case to the Personal Injury Protection Dispute Resolution Process.

Procura will inform the provider of their right to appeal and the procedure to follow when the review determination is made. The appeal may be made to a state certified Medical Review Organization through National Arbitration Association, at 732-271-6100. Forms, rules and procedures are available online at www.nj-info@arb-forum.com.

FAILURE TO COMPLY WITH POLICY REQUIREMENTS:

Under the terms of the policy, Duties after an Accident or Loss, you are required to cooperate with the insurance company's requests for additional information necessary to complete the investigation of the loss, to attend Independent Medical Examinations as often as we reasonably may require, to answer questions Under Oath, to submit a proof of loss, and to authorize us to obtain records. Any failure to cooperate shall result in a denial of your no-fault claim.

Medical Authorizations are NOT a guarantee for payment. All claims are subject to regulatory eligibility and coverage investigations, reductions and/or denials as required by the state of New Jersey.

INELIGIBILITY:

Upon receipt of all requested documents and the completion of any investigation as needed, should you be determined to be ineligible for benefits under the terms of this policy, your no-fault claim shall be denied.

Medical Authorizations are NOT a guarantee for payment. All claims are subject to regulatory eligibility and coverage investigations, reductions and/or denials as required by the state of New Jersey.

CONCEALMENT OR FRAUD:

There is no coverage under this policy if your or any other person insured under this policy has made false statements with the intent to conceal or misrepresent any material fact or circumstance in connection with any claim under this policy.

Medical Authorizations are NOT a guarantee for payment. All claims are subject to regulatory eligibility and coverage investigations, reductions and/or denials as required by the state of New Jersey.

EXHIBIT A Identified Injuries

The following **International Classification of Diseases, 9th Revision Clinical Modification**- fifth edition ICD-9-CM diagnostic Codes are associated with Care Path 1 through Care Path 6 for treatment of Accidental Injury to the Spine and Back and are included on each appropriate Care Path. The ICD9 codes referenced do not include codes for multiple diagnoses or co-morbidity.

Care Path 1

- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of Muscle
- 739.0 Non allopatic lesions- not elsewhere classified

- 739.1 Somatic dysfunction of cervical region
- 847.0 Sprains and strains of neck
- 847.9 Sprains and strains of back, unspecified site
- 922.3 Contusion of back
- 922.31 Contusion of back, excludes interscapular region
- 953.0 Injury to cervical root

Care Path 2

- 722.0 Displacement of cervical 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
- 728.0 Disorders of muscle, ligament and fascia
- 739.0 Non allopathic lesions- not elsewhere classified
- 953.0 Injury to cervical root

Care Path 3

- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of muscle
- 739.0 Non allopathic lesions- not elsewhere classified
- 739.2 Somatic dysfunction of thoracic region
- 739.8 Somatic dysfunction of rib cage
- 847.1 Sprains and strains, thoracic
- 847.9 Sprains and strains of back, unspecified site
- 922.3 Contusion of back
- 922.33 Contusion of back, interscapular region

Care Path 4

- 722.0 Displacement of cervical intervertebral disc without myelopathy
- 722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
- 722.11 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
- 722.72 Intervertebral disc disorder with myelopathy thoracic region
- 728.0 Disorders of muscle, ligament and fascia
- 739.0 Non allopathic lesions- not elsewhere classified

Care Path 5

- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of muscle
- 739.0 Non allopathic lesions- not elsewhere classified
- 739.3 Somatic dysfunction of lumbar region
- 739.4 Somatic dysfunction of sacral region
- 846 Sprains and strains of sacroiliac region
- 846.0 Sprains and strains of lumbosacral (joint) (ligament)
- 846.1 Sprains and strains of sacroiliac ligament

- 846.2 Sprains and strains of sacrospinatus (ligament)
- 846.3 Sprains and strains of sacrotuberous (ligament)
- 846.8 Sprains and strains of other specified sites of sacroiliac region
- 846.9 Sprains and strains, unspecified site of sacroiliac region
- 847.2 Sprains and strains, lumbar
- 847.3 Sprains and strains, sacrum
- 847.4 Sprains and strains, coccyx
- 847.9 Sprains and strains, unspecified site of back
- 922.3 Contusion of back
- 922.31 Contusion of back, excludes entescapular region
- 953.2 Injury to lumbar root
- 953.3 Injury to sacral root

Care Path 6

- 722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
- 722.10 Displacement of lumbar intervertebral disc without myelopathy
- 722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
- 722.70 Intervertebral disc disorder with myelopathy, unspecified region
- 722.73 Intervertebral disc disorder with myelopathy, lumbar region
- 728.0 Disorders of muscle, ligament and fascia
- 739.0 Non allopathic lesions- not elsewhere classified
- 953.4 Injury to sacral root

The following **ICD-9-CM** supplemental classification of external causes of injury may be used in addition to the specific diagnostic codes noted above and on each Care Path:

- E 810 through E 819, selected E 820 series codes.

These codes may be used to indicate cause of injury as motor vehicle accident but should not be used without an associated diagnostic code.

ADDENDUM TO CARE PATHS

1. Medications

Muscle Relaxants

! Muscle relaxants are an option in the treatment of patients with acute neck, thoracic, and low back problems. While probably more effective than placebo, muscle relaxants have not been shown to be more effective than NSAIDs.

! No additional benefit is gained by using muscle relaxants in combination with NSAIDs over using NSAIDs alone.

! Muscle relaxants have potential side effects in 30 percent of patients. When considering the option of using relaxants, the clinician should balance the potential patient's intolerance of other agents.