PROGRESSIVE®

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**[1] (See both the definition in this policy part and the listing by diagnosis code identified as 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**, **insured persons** or their **health care providers** 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 Progressive Decision Point Review Plan is available in hard copy by calling Procura Management Inc. at 1-800-275-9485, and is also available at http://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), **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
- All Non-Emergency Psychological/Psychiatric Services

[1] Terms in bold are defined terms in the insurance policy contract.

- 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 or rental over 30 days.
- Physical, Occupational, Speech, Cognitive, or other restorative therapy or 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**.

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 Procura Management Inc. at **decision points** and for Treatment, Diagnostic Testing or DME requiring **precertification** is not required.

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Treatment administered in **emergency care** and / or within ten 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 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/precertification** 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. For benefits to be reimbursed in full, treatment, testing and durable medical equipment must be medically necessary.

Complete requests

Complete requests for **decision point review** and **precertification** consist of the **insured person's** full name and birth date, the policy number, the claim number, and the date of the accident. 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, your provider will be informed by Procura Management Inc. 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. Upon receipt of all appropriate documentation, within three business days following receipt, Procura Management, Inc. will provide its determination. Pursuant to NJAC 11:3-4.4(d) and the policy of insurance, failure to comply with **decision point review** or **precertification** requirements will result in a 50% penalty copayment for any subject treatment or testing that is determined to be medically necessary and causally related to the **accident**. This penalty copayment will apply to care furnished between the time notification of treatment

is required and the time **we** or Procura Management Inc. have had an opportunity to respond after receipt of the requested additional medical documentation.

How to submit decision point/pre-certification requests:

Decision point / **precertification** requests 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 **health care provider** must submit all requests on the Attending Provider Treatment Plan form. A copy of the Attending Provider Treatment Plan form is available at http://www.nj.gov/dobi/aicrapg.htm or by contacting Procura Management Inc. at 1-800-275-9485, or at http://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** / **precertification** requests and/or extended treatment notifications will be completed within three business days following the day 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 Procura Management Inc. fails 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** or Procura Management Inc. are unable to make an informed determination based solely on the medical documentation, **we** or Procura Management Inc. may request that the **insured person** attend an Independent Medical Examination. If an Independent Medical Examination is requested, the appointment for the physical examination will be scheduled within seven calendar days of receipt of the notice, unless the injured person agrees with Procura Management Inc., or with **us,** to extend the time period.

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 to the health care provider in writing and by telephone within three 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 requested medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the IME. If the injured person has two or more unexcused failures to attend the scheduled exam, or three failures in total 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 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** from Procura Management Inc. 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 Copayment)

As outlined in N.J.A.C. 11:3-4.8, there is a copayment applicable to certain non-emergency care and services received from non-network providers. Currently, there is a 30% copayment 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 $50.00 cost or rental over 30 days. The copayment for prescription drugs is $10.00

Procura Management Inc. has a provider network that is available to **insured persons**. 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 copayment 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 Procura makes 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 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 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(d), failure to request **decision point review** or **precertification** as required in this Decision Point Review/Precertification plan will result in a 50% copayment penalty. This copayment penalty will be in addition to any copayment set forth elsewhere in Part II of the policy. Copayments and deductibles will first be applied to the eligible charges and then copayment penalties will be applied for failure to precertify.

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 pre-certification 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 this 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.

Internal appeal process and dispute resolution

If the **insured person**, or their **health care provider**, disagrees with **our** determination related to **decision point review**, **precertification** or payment of medical expenses, the **insured person**, or the **health care provider**, may submit an internal appeal for reconsideration of the decision. All requests for reconsideration should include the basis for the appeal. The **insured person**, and/or the **health care provider**, may be requested to submit additional documentation in order to complete the internal review.

The request should be submitted in writing to Procura Management Inc. at:

Procura Management Inc.
2435 Boulevard of the Generals, Suite 200

Norristown, PA, 19403.

Or the request may be faxed to (610) 631-7011. All requests for reconsideration will be reviewed within 10 business days from receipt of the notice and all supporting documents. A Procura Medical Director will be available to consult with the **health care provider** during the reconsideration process. A final decision will be communicated to the **insured person**, and the **health care provider**, in writing within 10 business days of receipt of the request for reconsideration and/or receipt of any supporting documentation we may request.

Pursuant to N.J.A.C. 11:3-5, and the policy, any dispute that has not been resolved through the internal appeals process may be submitted to Alternate Dispute Resolution.

Note: Health care providers who have accepted an assignment of benefits <u>must</u> submit an internal appeal for reconsideration of decisions related to **decision point review**, **precertification** or payment of medical expenses to Procura Management Inc. as outlined above. Any other disputes, or any disputes not resolved through reconsideration by Procura, must be submitted to **us** as required by the policy. If, despite completion of the internal appeal process, the good faith efforts of both parties fail to bring resolution to the dispute, the assignee's only recourse will be to request Alternate Dispute Resolution in accordance with N.J.A.C. 11:3-5.

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 allopathic 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 interscapular 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
953.3 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.